Shrishankara Superspeciality Hospital

Plot No 58, Opposite Galaxy Hospital, Near Dr Ban's Prasad Hospital,
Old Borban Factory Area, Nanded. 96577 13801

TRANSFER / REFERRAL FORM

PATIENT NAME : DATE :

AGE : SEX: UID NO :

IPD NO : BED NO :

INCHARGE DOCTOR :

DIAGNOSIS :

TREATMENT DETAILS :

VITALS AT TRANSFER

B.P - PULSE - R.R

OTHER

MENTAL STATUS :

CONDITION OF PATIENT AT THE TIME OF TRANSFER:

COPY OF TREATMENT DOCUMENTATION ATTACHED : YES ◯ NO ◯

ATTACHMENTS WITH PATIENT

REASON FOR TRANSFER

TRANSFER TO :

TRANSFER ADVICED BY :

ATTENDING STAFF :

CONSENT FOR TRANSFER

I/WE, AM/ARE WILLING TO TRANSFER THE PATIENT NAME…….
……. AS PER ADVISE OF DOCTOR.THE REASON FOR TRANSFER,CONDITION OF PATIENT,TREATMENT,RISKS AND CONSEQUENCES ETC. HAVE BEEN EXPLAINED TO ME/US AND UNDERSTOOD BY ME/US.

मी/आम्ही आमचा रुग्ण नाव .....याला डॉक्टरांच्या सल्ल्यानुसार या रुग्णालयातून हलविण्यास परवानगी देत आहोत.रुग्णालयातून हलविण्याचे कारण,रुग्णाची आरोग्य स्थिती,त्याला देण्यात आलेली चिकित्सा, फायदे आणि धोका याबाबत मला समजाविण्यात आलेले आहे आणि आला ते समजले असून मी रुग्णास हलविण्यास संमती देत आहे.

SIGNATURE OF PATIENT	SIGNATURE OF WITNESS	SIGNATURE OF MEDICAL OFFICEER
Date: / /20	Date: / /20	Date: / /20
Time:	Time:	Time: