Transfer to the Emergency Department (E.D.)

Patient's Name *(Surname/Given Name)*:	
Date of Birth *(yy/mm/dd)*:	**HCN:**
Today's Date *(yy/mm/dd)*:	

<table>
<tr><td colspan="2">Drug Allergy:</td><td>Med List Attached: Yes/No</td></tr>
<tr><td colspan="3">Situation (Reason for 911 Call/Current Situation) ☐ Medical Situation ☐ Safety Concerns</td></tr>
<tr><td>☐ Next of Kin/POA</td><td>Name:
Phone Number:</td><td>Aware of Transfer to ED
☐ Yes ☐ No</td></tr>
<tr><td>☐ Family MD</td><td>Name:
Phone Number:</td><td>Aware of Transfer to ED
☐ Yes ☐ No</td></tr>
</table>

Background *(Diagnoses; Recent Hospitalization and/or ED Visits, other relevant background/information)*
Assessment *(Acute Changes: Medical/Functional/Cognitive)*
Recommendation/Plan

Completed By:			
	Name/Designation	Signature	Cell Number

Care Co-ordinator:		Ext