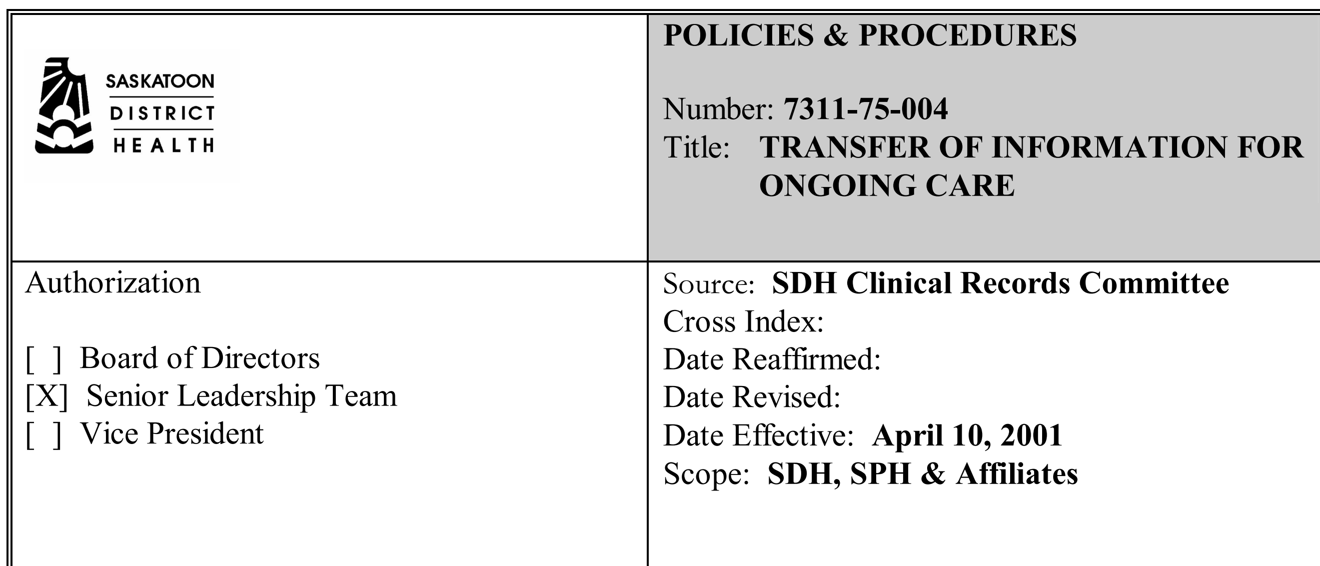

SASKATOON DISTRICT HEALTH	**POLICIES & PROCEDURES** Number: **7311-75-004** Title: **TRANSFER OF INFORMATION FOR ONGOING CARE**
Authorization [ ] Board of Directors [X] Senior Leadership Team [ ] Vice President	Source: **SDH Clinical Records Committee** Cross Index: Date Reaffirmed: Date Revised: Date Effective: **April 10, 2001** Scope: **SDH, SPH & Affiliates**

1 POLICY

1.1 Appropriate information will be sent upon, or prior to, patient/ client/ resident transfer to or from a SDH and affiliate agency or service.

1.2 "Appropriate" information is defined as such information required on a "need to know" basis to continue effective quality care for the patient/ client/ resident.

1.3 All health information will be managed confidentially.

2 PURPOSE

2.1 Transfer of appropriate health information from one care provider or service provider to another, for the purposes of on-going care, ensures a smooth transition of services and care for the patient/ client/ resident.

3 PROCEDURE

3.1 Health information will be sent in an envelope or chart binder.

3.2 The transferring unit is responsible transferring the appropriate documentation. Refer to the following table.

SERVICE DELIVERY TRANSFER	TRANSFER OF INFORMATION & FORMS REQUIRED	Phone contact required from transfer unit
3.2.1 Transfer from Acute Care		
♦ **To Acute care** - inpatient unit same site - inpatient unit on another site - outpatient unit - diagnostic services - including psychiatry	- Current chart will be transferred with patient, either in the chart binder or in a sealed envelope. Historical (old) chart must remain on the originating site. - A brief summary of patient condition should be documented in the Progress Notes. - Medical orders do not need to be reordered upon arrival. - Psychiatry – If patient is certified, completed Form L and include with chart. - Refer to "Interagency transfer of Health Records" policy 7311-75-001. Verbal communication between units is required. Transferring nursing unit notifies the next-of-kin, with consent of the patient.	Yes
♦ **To SCH Rehab**	As required for Acute Care inpatient.	Yes
♦ **To an out-of-district hospital**	Physician to physician contact must be done. The following documents should be sent upon transfer with patient. - Completed *Interagency Transfer* form (#100635) Copies of: - recent Lab, ECG & diagnostic findings - pertinent consults, Therapies assessment/plans, infectious disease status - Physician progress note summary/letter - pertinent Physician orders	Recommended
♦ **To CATU**	Copies of the following are sent: - Lab reports - Pertinent consults - Nurses notes - Physician notes and orders - Pertinent protocals - Brief discharge summary - Recent MAR sheet	Yes

SERVICE DELIVERY TRANSFER	TRANSFER OF INFORMATION & FORMS REQUIRED	Phone contact required from transfer unit
♦ **To Long Term Care – Special Care Homes**	The following documents should be sent upon transfer with patient. - Completed *Interagency Transfer* form (#100635) Copies of: - recent Lab, ECG & diagnostic findings - pertinent consults, Therapies assessment/plans, infectious disease status - Physician progress note summary - pertinent Drs. Orders Discharge summary will be sent when available.	Yes
♦ **To Psych Home Care**	- Completed *Interagency Transfer* form (#100635) - assessment/care plans, infectious disease status - Physician progress note summary - pertinent Drs. Orders	
♦ **To GRU**	As required for LTC	Yes
♦ **To GAU**	As required for inpatient Acute Care	Yes
♦ **To Home Care** **- Saskatoon District**	- Consult to CAU - will transfer all specifics from inpatient chart to community service. - Nursing home care services requires Home Care referral with either signed orders on the referral or copies of the physician orders. - Unit patient education or discharge instructions should be sent with patient – can be shared with Home care staff.	No
- Rural Health	- Consult to CAU for coordination. - Completed *Interagency transfer* form (#100635). - Unit patient education or discharge instructions should be sent with patient to share with Home care staff.	No
- First Nations Home Care	- Social Work will send consults directly to Federal office. - Unit patient education or discharge form should	No

SERVICE DELIVERY TRANSFER	TRANSFER OF INFORMATION & FORMS REQUIRED	Phone contact required from transfer unit
	be sent with patient to share with Federal staff.	
♦ **To Home**	Discharge instructions & related Patient Education materials should be sent with the patient.	No
3.2.2 Transfer from Long Term Care (LTC)		
♦ **To another LTC site**	- Completed *Interagency transfer* form (#100635) or a copy of the care plan to be sent - Pertinent other consults or information should be sent. - CAU will send the assessment form - The Health Record remains on site.	Yes
♦ **To Emergency** (including other Out-patient visits when information required)	- Completed *Emergency-Care Home transfer* form (#101652). - Copy of the *Medication Administration Record* (MAR) may be sent.	Recommended
♦ **To Acute care** (inpatient admission)	- Completed *Interagency transfer* form (#100635) - Copy of the MAR should be sent	No
♦ **To Home -** following Respite admission	Discharge Care plan, education materials and medication list sent with family.	Yes
♦ **To private care home** following Respite admission	- CAU will coordinate the admission. - Completed *Interagency tran*sfer form (#100635)	Yes
3.2.3 Transfer from Home Care/ Community Services		
♦ **To Acute care (Emergency)**	- Home care may use *Emergency Care Home transfer* form #101652 - Private care homes should use *Emergency Care Home transfer* form #101652 - Home Care nurse may communicate directly with Emergency dept. or family doctor - Upon admission, appropriate information should be shared with Acute care.	Recommended
♦ **To LTC**	CAU will send CAU assessment form.	Yes
♦ **To MHS**	Access through MHS Central Intake	

SERVICE DELIVERY TRANSFER	TRANSFER OF INFORMATION & FORMS REQUIRED	Phone contact required from transfer unit
	Refer to MHS policies for information transfer	
3.3.4 Transfer from out of district to Saskatoon - Inpatient services		
♦ **To Acute Care - including Palliative Care Unit**	Physician to physician contact must be done, including arrangements for admission. Referral accepted by physician. The following documents should be sent upon transfer with patient. - *Interagency Transfer* or *Nurse to Nurse* forms Copies of: - recent Lab, ECG & diagnostic findings - pertinent consults, Therapies assessment/plans, - Physician progress note summary/letter - pertinent Physician orders CAU is notified by out-of-district Home Care for follow up.	Recommended
♦ **To SCH Rehab**	Referral accepted by physician - As for Acute care	Recommended
♦ **To GRU**	Referral accepted by physician - As for Acute care	Recommended
♦ **To GAU**	Referral accepted by physician - As for Acute care	Recommended
♦ **To LTC**	Referral must be done through CAU.	No
♦ **To MHS** (Mental Health Services)	Inpatient - Referral accepted by physician – As for acute care. All other MHS services - access through MHS Intake Unit.	Recommended
♦ **To Addictions**	Referral required for residential programs.	No