

This document is used for continuous quality improvement and is protected and confidential.

TCF Patient (transfer) Follow-Up Request Form

(This section to be completed by the requesting (transferring) TCF)

Patient Name:			
Date of Transfer:	___/___/___	Transferred By:	
Transferring Agency: Address: City/State/Zip:			
Transferring Surgeon:			
Transferring ED Physician:			
Other Transferring Physician:			
TNC/TC & Phone Number:	() -		

(This section to be completed by the receiving TCF)

Diagnoses known as of this date:	

Diagnostics & procedures performed to date:	

Known problems with transfer:	

Additional comments:	
<i>(Attach discharge summary to this document)</i>	

ISS:		Probability of Survival:		Admit GCS:		Admit RTS:	
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Attending trauma surgeon:			
Other attending physician:			
Other attending physician			
Name of person completing form:		Title:	

Signature: _____ **Date:** ___/___/___

*Please return this form to the requesting TCF, at the above address, as soon as possible.
Submit QI documentation to hospital QM department.*