## ERCP PROCEDURE

**TRANSFER RECORD**

(ERCP = Endoscopic Retrograde Cholangio-Pancreatography)

**PRE TRANSFER INFORMATION**

**Must be provided to HHS before transfer**

- **Lab Investigations (Most Recent Results)**
  - Date: (yyyy/mm/dd) ____________
  - INR _______ PTT _______
  - HBG _______ Platelets _______

- **Patient on Antiplatelet?**
  - No
  - Yes – Name of Medication ______________________________________
  - Last Dose Given: Date (yyyy/mm/dd) ____________ Time (hh:mm) ____________

- **Patient on Anticoagulants?**
  - No
  - Yes – Name of Medication ______________________________________
  - Last Dose Given: Date (yyyy/mm/dd) ____________ Time (hh:mm) ____________

- **Is patient able to give consent?**
  - No
  - Yes

  *(if no, sending facility must arrange for the SDM to accompany the patient)*

- **Isolation Precautions:**
  - No
  - Yes

  - Details: ____________________________________________

- **Cytotoxic Precautions:**
  - No
  - Yes

**TRANSPORT DETAILS**

- **Patient Transfer via stretcher only, must be arranged to and from hospital by sending facility with return ticket.**

  - Name of Transport ______________________________________
  - Return Time Booked (hh:mm) ____________

**Pre Transfer Information Submitted By:**

- (Printed Name) ___________________________ Ext. ____________

Fax the above completed information to 905-575-2679, before Transfer

**Sending Facility MUST review the following, prior to transfer:**

- [ ] IV In situ ________________
- [ ] Gown on Patient
- [ ] NPO at: Date (yyyy/mm/dd) ____________ Time (hh:mm) ____________

**TRANSFER TIME \rightarrow NURSE MUST ACCOMPANY PATIENT TO HHSC, and bring the following documentation:**

- MAR / Diabetic Profile
- History and Physical
- Imaging Reports and ERCP Films (on a CD) accompanying the printed report

**RN confirming above and accompanying patient:**

- (Printed Name) ___________________________

*Original completed form to accompany patient*