Hamilton Health Sciences

ERCP PROCEDURE TRANSFER RECORD

(ERCP = Endoscopic Retrograde Cholangio-Pancreatography)

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Sending Facility: _____

Ward: _____

Phone: _____ **Ext.** _____

Sending Physician: _____

Procedure: _____ **Date:** (yyyy/mm/dd) _____ **Time:** (hh:mm) _____

PRE TRANSFER INFORMATION

Must be provided to HHS before transfer

If abnormal lab results, sending facility must notify ERCP Physician, prior to transfer. Do not transfer patient unless instructed by the HHS ERCP Physician.

Lab Investigations (Most Recent Results) → **Date:** (yyyy/mm/dd) _____

INR _____ **PTT** _____ **HBG** _____ **Platelets** _____

Patient on Antilplatelet? ☐ 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 → 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