Physician to Physician Transfer

Must be completed at time of transfer to and from the State Hospital

Person's Name:	DOB:
Referring Facility:	Phone # ( )
Referring Physician:	Phone # ( )
Date of Admission to Referring Facility:	
Discharge Diagnosis (Current edition of DSM-5)	

Significant/Critical Events During Hospitalization (current status, suicide attempts/gestures, self injurious behavior, restraints, special precautions, etc.:

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Significant Medical History, Treatment & Diagnosis (Allergies, recent significant laboratory findings, med/surg procedures, etc.)

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Current Medications (List using additional sheet if necessary or attach current MAR)

Name of Medications	Dosage	Frequency	Lab Values	Taken Day of Transfer		
				Yes	Time Taken	No

Failed Medication Regimens:____

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Current Precautions (suicide precautions, elopement precautions, etc.):_____________________________

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Management Suggestions:____

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Signature of Physician *: ___________________________________ Date________________

Printed Name of Physician ______________________________ Physician's approved designee may sign in the absence of the physician

Use reverse or attach additional sheets if needed

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