|  |  |  |
| --- | --- | --- |
|  | **Transfert Request Form**  |  |

|  |
| --- |
| **A. From 1st Hospital** |
| Date |  | Clinician Name |  |
| Hospital Name |  | Phone Name |  |
|  |  |  |  |
| **B. Patient Identification** |
| First Name |  | Gender |  |
| Family Name |  | Nationality |  |
| Date of Birth |  | ID Number |  |
|  |  |  |  |
| **C. Prior Medical Conditions** |
| Underlying Conditions | 🗆No, 🗆Yes, specify: |  |
| Chronic Treatment | 🗆No, 🗆Yes, specify: |  |
|  |  |  |
| **D. Illness**  |
| Date onset |  |
| Symptoms | 🗆 Fever /history of fever🗆 Coughing | 🗆 Nasal discharge 🗆 Sore Throat  | 🗆 Dyspnea 🗆 Other:  |
| Severity | BP S/D:HR/mn:RR/mn:Sat O2 :Glasgow: | WBC count:Lymphocytes:Flu rapid test:Flu PCR: | pH:PaO2:PaCO2:HCO3-:Sat O2: | Chest XR: |
| **E. Exposure to COVID-19 (in 14 days prior to onset)** |
| Travel  | 🗆 No 🗆 Yes, specify | Country:  | Date of arrival: |
| Link with covid19 case | 🗆 No 🗆 Yes, specify | Name: |  |
| Professional activity | 🗆 No 🗆 Yes, specify | Profession: | Institution: |
| Social network | 🗆Contact with travelers | 🗆High contact with people | 🗆Social event/mass gathering |
| **F. Case management at 1st hospital** |
| Date of admission |  |
| Diagnosis |  |
| Treatment |  |
| Mechanical ventilation | 🗆 No 🗆 Yes, specify type: |  |
| Isolation | 🗆 No 🗆 Yes, specify starting date: |  |
| ICU | 🗆 No 🗆 Yes, specify starting date: |  |
| Outcome | Responsive to antibiotics: 🗆 No 🗆 Yes |  |
| **G. For RHUH**  |
| Criteria assessment |  |
| Transfer clearance | 🗆 Transfer | 🗆 Non transfer  |
| Nb of specimens need |  |  |
|  |  |  |
| **H. Notes** |
|  |