# ROYAL ALEXANDRA CHILDREN'S HOSPITAL-INTER-HOSPITAL SURGICAL TRANSFER CHECKLIST

Date: Time:

**Referring Hospital:**

**Referring Clinician:**

**Referring contact number:**

Name:

DOB:

Weight:

Provisional diagnosis:

**A-**

**B- RR Sa02**

**C- CRT P Temp**

**Secure IV Access**

**Fluid advice given**

**NG**

**Antibiotics (if appropriate)**

**CONFIRM THAT PATIENT STABLE TO TRANSFER TO RACH (CONSIDER STRS)**

**REQUEST TRANSFER WITHIN 1 HOUR IF PROVISIONAL DIAGNOSIS TIME CRITICAL**

**Request to be contacted prior to patient leaving**

Contact Bed manager and CED charge nurse

Consider discussion with - CED Consultant/Registrar

RACH medical team (if uncertain diagnosis)

Confirm patient clinical stability and ETA