STRAC
Southwest Texas Regional Advisory Council

Psychiatry Transfer Form v_10.15.2024

Coversheet for Transfers, Must be Completed

Affix Patient Label Here

To be filled out by Provider:

Provider shall be one of the following: MD, DO, APN, PA

Is the patient medically stable for transfer to a psychiatric facility? ☐ **YES** ☐ **NO**

Females between 12-60 yo, pregnancy test results:

☐ **Positive** ☐ **Negative** ☐ **N/A:** _____

Any abnormal vital signs at time of transfer?

- Temperature =>101F
- HR <50 or >120
- SBP <90 or >200
- RR >24
- BGL <60 or >250
- Outside normal range for pediatric age

☐ **YES** ☐ **NO**

Any active medical problems that will need to be addressed at the receiving facility (i.e.: suture/ staples needing to be removed, antibiotics for cellulitis or UTI, etc.) ☐ **YES** ☐ **NO**

If yes, please provide instructions:

_____
_____
_____
_____

Is the patient considered LOW RISK*?

(All of the following must apply to the patient)

- Young (equal to/less than 45 y/o)
- Presenting with isolated psychiatric complaint
- Past history of psychiatric illness
- No report of, or concern for, substance intoxication, withdrawal, or exposure to toxins/drugs
- History/physical exam does not suggest medical illness

☐ **YES** ☐ **NO**

**If patient is considered LOW RISK, no further diagnostic testing is required other than at the discretion of the Clinician.*

What is the working psychiatric diagnosis?

_____
_____
_____
_____

Completed by:_____

Title: _____

To be filled out by the Transfer Coordinator:

Is the patient under Emergency Detention/ Mental Health Warrant/ Magistrate ED?

☐ **YES** ☐ **NO**

If yes, date/time: _____

Is the patient under Order of Protective Custody (OPC)?

☐ **YES** ☐ **NO**

If yes, date/time: _____

For pediatric patients, provide the name and contact info for parent/guardian/CPS Case Worker:

_____
_____
_____
_____

Is the patient able to perform basic ADLs (transfer without assist, toilet, self-care, etc.)?

☐ **YES** ☐ **NO**

Does the patient require an assistive device for mobility?

☐ **YES** ☐ **NO**

If yes, what device? _____

Does the patient have inserted/implanted devices with external tubes/wires?

☐ **YES** ☐ **NO**

If yes, what device? _____

At the time of transfer, make sure the following items are included in the transfer packet:

- ❑ Nursing notes
- ❑ Clinician notes
- ❑ Lab results *(if performed)*
- ❑ Med Administration Record *(if meds given)*
- ❑ Copy of all legal documents

*(If person is on ED/MHW/OPC, the document **must** be forwarded to receiving facility)*

Completed by: _____

Title: _____