

67: 8738 8735

**SYDNEY SOUTH WEST**  
**AREA HEALTH SERVICE**  
**NSW HEALTH**

**INTER-HOSPITAL TRANSFER**  
**CHECKLIST - ENDOSCOPY**

Affix ID Label Here		MRN			
Surname		Given Names			
Address - Street		Suburb	Postcode		
Date of Birth	Sex	AMO			
Hospital Name				Ward	

**THIS CHECKLIST MUST BE COMPLETED AND Faxed 9828 3555 to the NUM of Perioperative Services, Liverpool Hospital prior to transfer. Referring Staff member: \_\_\_\_\_, contact number/pager: \_\_\_\_\_**

**DATE: \_\_\_\_\_ PROCEDURE: \_\_\_\_\_**

<b>TRANSFERRED FROM:</b> _____	HOSPITAL WARD	<b>SELECT ONE</b>
	HDU	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ICU	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>TRANSFER TO Liverpool Hospital:</b>	PERIOP UNIT	<input type="checkbox"/> Yes <input type="checkbox"/> No
	WARD	<input type="checkbox"/> Yes <input type="checkbox"/> No
	HDU	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ICU	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NUM of PERIOP VERIFICATION :</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

**NAME OF ACCEPTING PROCEDURALIST: \_\_\_\_\_**

<b>MOBILITY:</b>	<b>PATIENT STATUS:</b>	
	SIT UP	<input type="checkbox"/> Yes <input type="checkbox"/> No
	WALK	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>COMMUNICATION:</b>	REQUIRE ESCORT	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ABLE TO COMMUNICATE	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LUCID & COOPERATIVE	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IV ACCESS:</b>	SPEAKS ENGLISH	<input type="checkbox"/> Yes <input type="checkbox"/> No
	REQUIRES INTERPRETER	<input type="checkbox"/> Yes <input type="checkbox"/> No
	IV CANNULA IN SITU	<input type="checkbox"/> Yes <input type="checkbox"/> No
	INVASIVE LINES (e.g. arterial, central venous)	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CVS:</b>	<b>MEDICAL STATUS:</b>	
	HAEMODYNAMICALLY STABLE	<input type="checkbox"/> Yes <input type="checkbox"/> No
	UNSTABLE ANGINA	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>RESP:</b>	CCF	<input type="checkbox"/> Yes <input type="checkbox"/> No
	REQUIRE O <sub>2</sub> TO MAINTAIN SaO <sub>2</sub> >95%	<input type="checkbox"/> Yes <input type="checkbox"/> No
	UNABLE TO LIE FLAT	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>GIT:</b>	INTUBATED	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ACTIVE BLEEDING	<input type="checkbox"/> Yes <input type="checkbox"/> No
	FASTED more than 6 HOURS since FOOD	<input type="checkbox"/> Yes <input type="checkbox"/> No
	More than 3 HOURS since CLEAR FLUID	<input type="checkbox"/> Yes <input type="checkbox"/> No

**MEDICATIONS (List): \_\_\_\_\_**

**Infusions running (include vasoactive drugs, insulin, heparin, antibiotics, GTN) specify: \_\_\_\_\_**

**LABORATORY RESULTS ATTACHED or available on Powerchart**

LFT's FBC COAG UEC	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-RAYS	<input type="checkbox"/> Yes <input type="checkbox"/> No
SCANS	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Post PROCEDURE:**

TRANSFER BACK	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADMIT to Liverpool Hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No
AWAIT OUTCOME	<input type="checkbox"/> Yes <input type="checkbox"/> No

BINDING MARGIN - NO WRITING  
FILE IN CLINICAL RECORD

ORDER: PRINT ROOM (PHOTOCOPY)

**INTERHOSPITAL TRANSFER CHECKLIST - ENDOSCOPY**  
**15.2 (TRIAL)**