



Referral Transfer Form

Billings Clinic Transfer Request Phone Number 1-800-325-1774

Date _____

Demographics	Included
Face Sheet-DOB, Payer	
Referring Provider and contact number	
PCP and contact number	
Accepting Provider	
Mode of transportation	
Facility name and number	
Patient location in facility	
Family contact and number	

Clinical Patient Information	
Mental Status-alert & oriented, confused/combatative, obtunded	
Vital signs-weight, height, BP, O2 Sat	
Isolation	
Labs	
List of medications received at transferring facility	
Allergies	
Home medication list if available	
H&P/ER Note or Written Transfer Summary (see page 2)	
Discharge Summary	
Radiology Results-PACs or CD	
List of procedures performed	
Admitting diagnosis at current facility	
CPR Status	

Misc. Information	
Living Will	

Sent by: _____

Contact Phone # _____

Please provide additional information if patient is one of the following types:

For MFM Patients	Included
ACOG Data Base	
Ultrasounds	

For NICU Patients	Included
ACOG Data base	
Sample Cord Blood	
Newborn screen card	
6" piece umbilical cord	

Cardiology Patients	Included
EKGs	

Billings Clinic Referral Transfer Form - Page 2

Patient Condition Transfer Summary

Note to Transferring Provider: Please fill this form out if you are unable to send your History and Physical/ER report with the patient, as it will allow us to better care for your patient. If your documentation becomes available after the patient has already left your facility, please fax to: (406) 657-3756.

Pertinent Patient History

Pertinent home medications (if no list is being sent with nursing notes)

Pertinent Physical Examination

Pertinent lab work/radiological study results (if copies of documentation not sent)

Medications administered/Treatments /Procedures (if copies of documentation not sent)

Important clinical concerns/areas to be addressed