AMBULATORY CARE/EMERGENCY REFERRAL

(TO BE COMPLETED BY REFERRING PHYSICIAN)

DATE__________________TIME__________

REASON FOR REFERRAL/DESCRIPTION OF PROBLEM:__________________________________

ADMISSION TYPE: VOL/ INVOL/ COURT:__________

PRIMARY DISABILITY DIAGNOSIS
AND/ OR SOMATIC DIAGNOSIS:________________

SPECIAL PRECAUTION:____________________

ADVANCE DIRECTIVES/ DNR: YES____NO____

ALLERGIES:____________________________

TETANUS STATUS:_______________________

DIET:________________________________

CURRENT MEDS:_________________________

REFERRING PHYSICIAN'S SIGNATURE:____

AMBULATORY CARE/ ER NURSING ASSESSMENT:
(i.e., Skin Color, Respiratory Distress, Pain, General Behavior)

ATTACH FORM AS NECESSARY:
(Title of Document________________________

SIGNATURE:__________________________

DATE/HOUR OF ARRIVAL__________________

VITAL SIGNS

TIMES				
TEMP				
RESP				
PULSE				
B.P.				
LEVEL OF CONS				
OXYGEN				
SAT (%)				

DATE:______________ TIME_______________

NURSE'S NOTE:____

X-RAY________ TO:________ FROM:______

LAB COLLECTED:________RECEIVED:_______

EKG ORDERED:________________________

CT SCAN________TO:________FROM:______

ADMISSIONS REPORT TO:_________________

RM#:_________________________________

SIGNATURE:____________________________________

DISCHARGE DATE/ TIME________________

STAMP PLATE

M.D. NOTIFIED____________________________

DATE/TIME_______________________________

SIGNATURE_______________________________

CSH-59 (Revised 3-2001)

PHYSICIAN ASSESSMENT:

PRESENT ILLNESS:

PHYSICAL FINDINGS:

CONSULTATION: PLEASE ATTACH COMPLETED CONSULTATION FORM, CSH 22 (if applicable)

TIME	ORDERS CHECK ALLERGIES	DOCTOR'S SIGNATURE	TIME GIVEN	ROUTE	NURSE'S SIGNATURE

LAB/ X-RAY FINDINGS:

DIAGNOSIS/ IMPRESSION:

RECOMMENDATIONS/TREATMENT:

DISPOSITION: PARENT UNIT____________ADMIT____________CLINIC____________OTHER____________

PHYSICIAN SIGNATURE:__________________________________ DATE/TIME____________________

MODE OF TRANSPORT: EMS________STRETCHER________WHEELCHAIR________AMBULATORY________

AMBULATORY CARE / EMERGENCY REFERRAL
CSH - 59
CHD, DDD and PSD

This form must be imprinted with the patient's stamp plate by ward personnel.

TO BE USED FOR IMMEDIATE CARE ONLY

The referring physician must complete and sign the first section.
This section must include:

- a. reason for referral/description of problem/admission type
- b. infection/isolation status
- c. circle advance directive status
- d. allergies
- e. tetanus status/date of last tetanus injection
- f. present medication
- g. signature of referring physician

The ER nurse must complete and sign his/her assessment in the second section. Document vital signs, pulse, and oxygenation percentage.

The ER physician must complete his/her assessment, sign and date. Complete the disposition section.

Distribution:

Original

- If not admitted to MSH - parent ward record
- If admitted - MSH record

Copy

- If admitted to MSH - parent ward
- If not admitted - MSH record