

UT-Harris County Psychiatric Center
Transfer Clearance Form (Page 1 of 2)

PT's NAME: _____ Age: _____ Sex: _____

INTAKE DATA:

Transfer Facility: _____ L/S: **VOL** **INVOL**

Contact Person: _____ Fax: _____

Reason for Transfer: _____ Phone: _____

Can service be provided at your facility? (circle one) **YES** **NO**

Admitted/Arrived at Transfer Facility: Date: _____ Time: _____

Patient's Current Location (circle one) **ER** **ICU** **Med/Surg** **Inpt Psych** **Other:** _____

ADMINISTRATIVE CLEARANCE: (Circle one) **YES** **NO**

GIVEN: Date: _____ Time: _____

(Following conditions must be met for Administrative Clearance to be given)

CHECK ONE: **YES** **NO**

- | | | |
|---|-------|-------|
| 1) Bed Available ? | _____ | _____ |
| 2) Exclusion checklist completed by transfer MD: | _____ | _____ |
| 3) Staffing/Acuity appropriate to accommodate transfer: | _____ | _____ |
| 4) RN to RN Review: | _____ | _____ |

Staff's signature completing review: _____

For MD to MD clearance, call HCPC at 713-741-5000 and request medical clearance

MEDICAL CLEARANCE: (Circle one) **YES** **NO**

GIVEN: Date: _____ Time: _____

DIAGNOSIS: _____

Transferring MD: _____

Accepting MD (Printed): _____

Comments: _____

Name of Patient Registration staff notified: _____

