Greater Manchester Critical Care & Major Trauma

This form is for completion by the medical team wishing to refer their patient between intensive care units.

CRITICAL CARE HANDOVER FORM FOR A INTERHOSPITAL TRANSFERRED PATIENT

PATIENT DETAILS
Name:

DOB:

Hospital number:

NHS number:

Gender:

ICU TRANSFERRED FROM:

DATE OF TRANSFER:

CONTACT DETAILS OF TRANSFERRING UNIT

URGENT ENQUIRIES (eg. On-call Registrar):

ICU CONTACT NUMBER:

PAST MEDICAL HISTORY

BASELINE MOBILITY & RELEVANT SOCIAL HISTORY

PRESENTING COMPLAINT
Diagnosis:
History:

SIGNIFICANT EVENTS DURING CRITICAL CARE STAY

DRUG HISTORY
Allergies (with details of reactions):

Pre-admission (including transplant/methadone):

Critical therapies given including stat/loading doses and IVIG:

Current critical care medications (including sedation & anticoagulation)

MEDICATION	Start date

SYSTEM REVIEW

A- (Intubated/Tracheostomy/Date/Grade of intubation/Length of tube at teeth)

B- (Sp02 target/Ventilator settings/Details of bronchoscopy/Chest drains/Proned/Physiotherapy)

C- (MAP target/Fluid balance/Recent ECG and echo/Renal replacement)

D- (AVPU/GCS/RASS/Focal neurology/Analgesia/Emotional/psychological needs)

E- (Pyrexia/Bowels/skin integrity)

BLOOD TESTS

TYPE	DATE	RESULTS
FBC		
U+ES		
LFTS		
INFLAMMATORY		
COAGULATION		
ABG		
OTHER, including drug levels		

IMAGING

TYPE	DATE	RESULT SUMMARY

ACCESS/ LINES/ URINARY CATHETER

TYPE	LOCATION	ANTT Y/ N	DATE INSERTED

MICROBIOLOGY – Include routine and COVID swabs

TYPE	DATE		RESULTS/ SENSITIVITES

ANTMICROBIALS

ANTIMICROBIAL	INDICATION	MICRO INVOLVED Y/N	START DATE / DURATION

NUTRITIONAL PLAN

(Please include if any feed breaks occur in consideration to enteral medication)

INSULIN REQUIREMENTS

INTERVENTIONS NEEDING ACTION OR FOLLOW UP

(Please include contact details of relevant team if applicable)

Other key monitoring including drug levels/HbA1c/Follow up monitoring:

COMMUNICATION

Include details of Knowledge of diagnosis/Family updates/Relative and NOK information/Language barriers

ANY OTHER RELEVANT INFORMATION

REFERRER INFORMATION

Name:

Job title:

Consultant responsible:

Signature: