



*LOMA LINDA UNIVERSITY MEDICAL CENTER
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL*

P.O. BOX 2000 • LOMA LINDA, CALIFORNIA 92354

FACSIMILE TRANSMISSION COVER SHEET

To:

Facility:

Phone:

Fax:

From: LLUMC

Department: Transfer Center

Phone: 800-865-5862 opt 3

Fax: 909-558-0288

Date:

Pages including this cover : 2

RE: Transfer Center Request form for LLUMC Inpatient Transfers.

Confidentiality Notice

The information contained in this facsimile document may contain information that is privileged, confidential, and exempt from disclosure under applicable law and is intended only for the use of the individual or entity named above. If the recipient or reader of this document is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is **strictly** prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address. Thank you.



LOMA LINDA UNIVERSITY
MEDICAL CENTER

Transfer Center
11234 Anderson Street
Loma Linda CA 92354
(800) 865-5862 opt 3 Fax (909) 558-0288

For LLUMC MRN:

Patient Name/DOB/Sex:

Referring Facility Patient Identification

TRANSFER CENTER INPATIENT REQUEST

Along with this sheet, please fax face sheet, H&P, consult notes, labs, pertinent imaging/test results, last 7 days progress notes, and COVID PCR result. Please make sure to put "Secure" in the subject line to meet HIPAA requirements.

Requesting Facility:		Request Date:		Time:	
Requestor: <input type="checkbox"/> MD <input type="checkbox"/> SW <input type="checkbox"/> RN/CM <input type="checkbox"/> Other Name:		Phone:		Time:	
Facility Case Manager Name:		Phone:		Alt #:	
Case Manager Office Number:		Case Manager Office Fax:			
Reason for Transfer:		<input type="checkbox"/> HLOC <input type="checkbox"/> LLUH Managed Care <input type="checkbox"/> Risk Management <input type="checkbox"/> Family request <input type="checkbox"/> MD request <input type="checkbox"/> Insurance <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Other:			
Chief Complaint / Diagnosis/ Transfer Diagnosis:					
Service Requested:				Bloodless: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referring MD / Referring Service:			Referring MD Cell #:		
Specialist MD / Specialist Service:			Specialist Cell #:		
Requesting Level of Care:		<input type="checkbox"/> Acute <input type="checkbox"/> Acute Tele <input type="checkbox"/> Intermediate <input type="checkbox"/> ICU			
Current Level of Care (LOC):		<input type="checkbox"/> ICU <input type="checkbox"/> IMU/PCU/DOU <input type="checkbox"/> Tele <input type="checkbox"/> Med-Surg			
GTTS:		<input type="checkbox"/> Vent Date Vented:		<input type="checkbox"/> Bipap <input type="checkbox"/> Dialysis <input type="checkbox"/> IABP <input type="checkbox"/> Impella	
		<input type="checkbox"/> ECMO: <input type="checkbox"/> VV <input type="checkbox"/> VA		MRI: Elbow to Elbow:	
GCS (example: 4 + 6 + 5 = 15)		_____ + _____ + _____ = _____		Code Status:	
Unit/Room Number:		Unit Phone:			
Isolation Precautions:		Bariatric: <input type="checkbox"/> Yes <input type="checkbox"/> No		Weight: _____ Height: _____ Girth: _____	
Mental Status:		<input type="checkbox"/> Conservatorship <input type="checkbox"/> Psych Hold: _____ <input type="checkbox"/> Sitter <input type="checkbox"/> Inmate			
Insurance:		Insurance Auth:			
Insurance Case Manager:		Insurance CM phone #:			

COVID QUESTIONNAIRE

COVID + <input type="checkbox"/> Yes <input type="checkbox"/> No		PUI <input type="checkbox"/> Yes <input type="checkbox"/> No		Date test completed:		What type of test:	
Test results available? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date Test Results Expected:		<input type="checkbox"/> Never been tested	
Copy of results faxed to TC <input type="checkbox"/> Yes <input type="checkbox"/> No				Date Faxed:			
Is patient fully vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No				Type:		Completion Date:	
<p>1. Flu like symptoms within the last 14 days:</p> <p>Fever (T > 100)? <input type="checkbox"/> Yes <input type="checkbox"/> No Cough? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chills? <input type="checkbox"/> Yes <input type="checkbox"/> No Body aches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sore Throat? <input type="checkbox"/> Yes <input type="checkbox"/> No SOB? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. New onset changes in ability to taste? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Close contact with confirmed COVID-19 positive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Live or work in skilled nursing facility, shelter, homeless encampment, jail, board & care, or group home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					<p>What can LLUMC provide that your facility is unable to?</p> <p>Intervention/Procedure Needed</p> <p>Other pertinent information (e.g. vent settings)</p>		