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

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

FACSIMILE TRANSMISSION COVER SHEET

To: Referring Facility

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.

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

COVID QUESTIONNAIRE

COVID + ☐ Yes ☐ No	PUI ☐ Yes ☐ No	Date test completed:	What type of test:
Test results available? ☐ Yes ☐ No		Date Test Results Expected:	☐ Never been tested
Copy of results faxed to TC ☐ Yes ☐ No		Date Faxed:	
Is patient fully vaccinated? ☐ Yes ☐ No		Type:	Completion Date:

1. Flu like symptoms within the last 14 days:
   - Fever (T > 100)? ☐ Yes ☐ No Cough? ☐ Yes ☐ No
   - Chills? ☐ Yes ☐ No Body aches? ☐ Yes ☐ No
   - Sore Throat? ☐ Yes ☐ No SOB? ☐ Yes ☐ No
2. New onset changes in ability to taste? ☐ Yes ☐ No
3. Close contact with confirmed COVID-19 positive? ☐ Yes ☐ No
4. Live or work in skilled nursing facility, shelter, homeless encampment, jail, board & care, or group home? ☐ Yes ☐ No

What can LLUMC provide that your facility is unable to?
Intervention/Procedure Needed
Other pertinent information (e.g. vent settings)