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/MRN:

TRANSFER CENTER INPATIENT REQUEST

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

LLUMC Transfer Center Website - https://lluh.org/health-professionals/referring-providers/patient-transfer-center

Requesting Facility:			Admission Date:	
Transfer Center Name (if any):	Phone:		Fax #:	
Facility Case Manager Name:	Phone:		Fax #:	
Unit Phone Number:	Patient Room/Bed:			
Reason for Transfer: ☐ HLOC ☐ LLUH Managed Care ☐ Risk Management ☐ Family request☐ Insurance ☐ Continuity of Care ☐ Other:				
Chief Complaint / Diagnosis/ Transfer Diagnosis:				
What can LLUMC provide that your facility is unable to? Intervention/Procedure Needed?				
Service Requested:				
Referring MD / Referring Service:		Referring MD Cell #:		
Specialist MD / Specialist Service:		Specialist Cell #:		
Current Level of Care (LOC): ☐ ICU ☐ IMU/PCU/DOU/SD ☐ Tele ☐ Med-Surg		☐ Psych Hold: ☐ Sitter ☐ Inmate		
Requested Level of Care: ☐ ICU ☐ IMU/PCU/DOU/SD ☐ Tele ☐ Med-Surg				
	☐ Bipap ☐ Dialysis ☐ IABP ☐ Impella ☐ Bariatric			
GTTS:	Elbow-to-elbow width:	Weight:	Height:	Girth:
	☐ ECMO: ☐ VV ☐ VA	☐ Date Vented:		ECMO: Send last ABGs
Insurance/IPA/MG:	Insurance Auth Number/Contact Person:			
Insurance Case Manager:	Insurance CM phone #:			
Isolation Precaution:				
COVID + ☐ Yes ☐ No	PUI ☐ Yes ☐ No	Date test completed:	What type of test:	
Candida Auris Screening (Required for Infection Control): Has patient been in a SNF, Rehab, or LTACH facility in the last 90 days? ☐ Yes ☐ No Name of Facility_____ Has patient ever tested positive for C. Auris? ☐ Yes ☐ No Date of test:	**Other pertinent information (e.g. vent settings)**			