TEMPORARY TRANSFER FORM

For use when sleep-over arranged within the Trust

(Not to be used for Trust patients Sectioned under the MHA)

SAMPLE - DO NOT USE

Patient's name				
Ward/Unit	From			
	To			
Temporary transfer commenced	Date		Time	

1	The transferring ward/unit to arrange the transport to drop off and pick up their patient (8.00 pm to 8.00 am)?	Yes / No
2	Medication sent and clearly marked to cover prescribed night and morning medication? Ensure drug name on the foil if in blister packs, if possible	Yes / No
3	Medication card sent?	Yes / No
4	Notes included?	Yes / No
5	Special needs – please specify, e.g. sensitivities, disability, preferred language, dietary needs, etc.?	Yes / No
6	Care plan included?	Yes / No
7	Current risk assessment included?	Yes / No
8	Safeguarding concerns shared with the receiving team?	Yes/No/NA
9	Infection Risk (on Admission/Transfer) form ICPGI Section 4 completed?	Yes / No
10	Sleep-over discussed and agreed with patient?	Yes / No
11	Has the patient been made aware of the receiving ward/unit's night routine?	Yes / No
12	Does the service user have an established sleep pattern?	Yes / No
	If response is 'no', please provide details of night sedation care plan	
13	State patient's current level of observation	

14	Relevant belongings assembled and listed?	Yes / No

15	**In the event of any queries, please contact -**			
	Name (printed)		Phone number	
16	**Person completing this form --**			
	Name (printed)			
	Signature		Designation	

ONLY COPIES OF RELEVANT INFORMATION SHOULD BE GIVEN TO RECEIVING EXTERNAL TRUSTS