BCCH INTERHOSPITAL TRANSFER REQUEST FORM

PATIENT INFORMATION

CAPE Unit – BC Children's Hospital
Mental Health Building
Entrance 1, 2nd Floor
4555 Heather Street

Vancouver, BC
Phone: 604-875-2075
Fax: 604-875-2208

To: Referring Physician,
Please read the information provided

From: Child and Adolescent Psychiatry Emergency Unit CAPE

Hospital & Unit:	**Physician:**
Phone:	**FAX:**
Re:	**Date and Time:**

The Child and Adolescent Psychiatric Emergency Unit (CAPE) at BC Children's Hospital has received a request for transfer from your facility. We service children and adolescents up to and including the age of 16 years.

BC Children's Hospital Child & Adolescent Psychiatric Emergency Unit (CAPE) provides short term psychiatric services for children and youth age 16 and under from BC and the Yukon Territories experiencing a mental health crisis. The collaborative, interdisciplinary team provides care focused on stabilization, initiation of treatment, and connection to community resources.

CAPE services include but are not limited to:
· Psychiatric and medical assessment
· Medication review
· Initiation of treatment
· Psychoeducation for children & families
· Safety planning
· Connection to community resources

1) **All transfers must be certified – Please fax the documentation to 604-875-2208:**
   - British Columbia Children's Hospital Interhospital Transfer Form
   - Mental Health Act forms 4 and 5
   - The most recent Psychiatric Evaluation
   - Physical Examination and pertinent lab results to ensure medical stability

Please note: This form must be completed by sending facility prior to acceptance of patient.

Prior to acceptance: Our Psychiatrist and/or Psychiatric resident will review the above documentation, contact you, advise you of bed availability and inform you if the patient will be accepted for transfer. Patients must be medically stable with documented medical clearance.

2) Once the patient has been accepted for transfer please:

- Contact the CAPE unit at 604-875-2075 to inform them of the transfer arrangements and provide a verbal Nurse to Nurse handover highlighting safety concerns.
- Ensure the guardians/caregivers are informed (if MCFD is involved please update them or ask the family to provide and update as appropriate)
- Ensure the patient has all of their personal items requires for a stay
- FAX or provide photocopies of the patient chart including:
  - Physician Orders and documentation
  - including name of accepting MRPs should repatriation be requires
  - Medication Administration Records
  - Last 72 hours of nursing notes
  - All Consults including Emergency Room visit

- The CAPE Unit must be called when the patient departs from your facility for a patient status update

3) At the end of an admission on CAPE, youth are discharged back to their home environment or if alternative placement is needing to be arranged in their home community the youth will return to the sending site to await placement. Youth may also be discharged from CAPE and require repatriation to the sending site due to safety/logistical concerns regarding return to their home community.

Should the patient require repatriation, please indicate the most responsible physician at the sending site who would be contacted should repatriation be required:

(MRP with admitting privileges): _____ at _____(facility)

Contact Information _____

All transfers must be Physician to Physician. Admissions arriving between 09:00 and 16:00 may come directly to the CAPE unit unless sedation is required. Admissions after 16:00 must go to emergency, unless a Psychiatrist is available on the CAPE unit to receive them. If CAPE is unable to accept the patient for transfer due to bed availability, call (604-875-2075) the following morning and speak to CAPE Nurse in Charge to determine bed availability and acceptance for transfer. Special consideration is given to transport via air-ambulance, remote regions, and specific patient circumstances.

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PATIENT INFORMATION

PATIENT INFORMATION *(check all that apply)* Preferred name/pronouns:

☐ **Patient Identity Verified:** [1]: [2]:

Date Admitted to Hospital: MONTH / DD / YY Age:

Est. Date & Time of Admit: MONTH / DD / YY @ TIME

Has a referral been made to another program/institution – YES/NO
If YES, WHERE?:

Equipment Required for Patient:

Legal Guardians (specify relationship to Patient) Contact:

Contact:

☐ Legal Guardians notified: MONTH / DD / YY @ TIME ☐ **MCFD involved?** SPECIFY

☐ **MCFD Alerts:** **Last Residence** ☐ Foster Home ☐ Parents Home ☐ Other/Specify

Diagnoses (Psychiatric and Medical)

Psychiatric Diagnosis:

Infectious Diseases/Covid screened?: **Head Lice: Yes/No**

Current Vital Signs: B/P HR Resp Pulse

☐ Substance Use : ☐ Consult Services Involved:

☐ **ALLERGIES:** ☐ NKA ☐ **MEDICAL ALERTS:** (e.g. sutures, burns, tubes, seizures, etc.)

RISK ASSESSMENT

☐ SUICIDAL IDEATION: ☐ Active /Recent: MONTH / DD / YY ☐ in History ☐ Attempts

☐ Self-Injury:

☐ Aggression ☐ Physical ☐ Verbal ☐ Homicidal Ideation

☐ Active Psychosis ☐ Delusions ☐ Hallucinations *Specify:*

☐ Elopement Risk Other Precautions:

☐ Last Time Seclusion Needed MONTH / DD / YY

Special Observation Level: ☐ 1:1 Supervision ☐ Constant Obs. ☐.Other/please specify

Reason for Level:

MEDICATIONS ☐ N/A

☐ Last scheduled medication administered:

☐ Next medication dose due:

☐ Last PRN medication administered: @ TIME MONTH / DD / YY

@ TIME MONTH / DD / YY

@ TIME MONTH / DD / YY

MENTAL HEALTH ACT FORMS

Certification:	☐ YES	☐ Involuntary Form 4 & 5 completed	☐ Form 13 (rights)
	☐ NO	☐ Voluntary Form 1 & 2 completed	☐ Form 14 (rights)

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