## **System Performance Improvement Committee**

**Transfer Follow-Up Guidelines**

**Purpose**: To provide consistent feedback and follow up for trauma patients transferred within the Regional network.

**Guideline**: Receiving trauma center will complete a transfer follow-up tool and forward the document to the transferring facility within 30 to 45 days of the transfer.

**Procedure**:

1. The patient’s initials will be used as the identifier with the date and time of transfer.
2. Injuries identified in the trauma evaluation will be listed.
3. Disposition from the emergency department are to be listed.
4. Operative procedures will be listed (initial operative intervention).
5. Patient’s status during the first 48 hours will be defined.
6. Compliance to EMTALA regulations will be reviewed.
7. Performance improvement measures will be reviewed.
8. Feedback, transfer review tool will be forwarded to the Regional Outreach coordinator within 14 days (business days) of the transfer.

**System Improvement Process Form**

Patient Initials:

Date of Transfer:

Mechanism of Injury:

Transferring Facility:

Transferring Physician:

Identified Injuries:

Additional Interventions/Findings at Receiving Institution ED:

ED disposition:

Initial Surgical Interventions performed:

Discharged/Disposition:

Contact Name and information of individual completing this form:

CONFIDENTIAL: This report is prepared pursuant to, but not limited to, (P.A. 368 of 1978). This report is a review function and as such is confidential and shall be used only for the purpose provided by law and shall not be public record and shall not be available for court subpoena.

**Transfer/Referral Review**

Date of Referral: \_\_\_\_\_\_\_\_ Pt. initials\_\_\_\_\_\_\_ MR# (listed above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, transferring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The transfer request call was answered promptly with efficient, courteous staff. If not, do you know who you spoke with?

 Exceeds Expectation  Meet Expectation  Needs Improvement Not Applicable

 Comment:

2. Patient transfer was accepted at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_in a timely, coordinated manner.

 Exceeds Expectation  Meet Expectation  Need Improvement Not Applicable

 Comment:

3. You received follow-up in a timely manner.

 Exceeds Expectation  Meet Expectation  Need Improvement Not Applicable

 Comment:

4. If you called our office with information or feedback request, you received prompt, timely service:

 Exceeds Expectation  Meet Expectation  Need Improvement Not Applicable

 Comment:

 Recommendations for improvement:

 Thank you in advance for your assistance and cooperation in evaluating our system. Our goal is to provide you, your staff, and the patients/family with quality service. If you have questions or would like to review specific issues, please feel free to contact us via email or at the numbers listed below. Please mail or fax completed form to:

Name and Contact Information of Individual to Receive information: