Health Information Transfer Form

Version: 2012

Pursuant to 95(1) (b) of the Correctional Services Act, sharing health information is necessary to ensure safety and continuity of care of a person in custody.

SECTION A MUST BE COMPLETED BY

a) If the transfer originates at a facility or hospital; a representative of the facility or hospital.
b) If the transfer does not originate at a facility or hospital; the transferring officer.

Name of person in custody: _____

Health card number (if known): _____ Date of birth: _____

Next of kin: _____ Telephone number: _____

SECTION B MUST BE COMPLETED BY THE TRANSFERRING OFFICER.

Conditions requiring ongoing attention:

☐ aggression towards others ☐ potential for self-harm ☐ physical health issues ☐ mental health issues

Statement of health status as observed by officer or reported by person in custody:

_____

_____

_____

_____

Assessed and/or treated by health care provider: ☐ Yes (If yes health care must complete section D.) ☐ No

Reasons for arrest: _____

Name: _____ Signature: _____

Designation: _____ Phone #: _____

SECTION C MUST BE COMPLETED BY A REPRESENTATIVE OF A FACILITY OR HOSPITAL. (applies if the transfer originates at a facility or hospital)

Conditions requiring ongoing attention:

☐ epilepsy ☐ high blood pressure ☐ alcohol/drug seizures ☐ heart problems
☐ diabetes ☐ contact lenses ☐ other prosthesis ☐ orthodontic appliances
☐ breathing problems ☐ infectious disease (if required, please attach a list of additional precautions for client, escorting and facility staff)

☐ potential for self-harm ☐ suicidal thoughts Does the person have : ☐ a plan ☐ the means ☐ personal history
☐ aggression towards others

Medications (if known) ☐ printout attached (or complete the following table)

Medication	Dose	Frequency	Time last administered

Medications transferred with person in custody? ☐ Yes ☐ No Known allergies: _____

Upcoming appointment (if known): _____

Name: _____ Signature: _____

Designation: _____ Phone #: _____

SECTION D MUST BE COMPLETED BY HEALTH CARE PROVIDER.

(applies if the person in custody being transferred receives care or treatment from a health care provider)

Principal/provisional diagnosis (physician only): _____

_____

Treatment provided: _____

_____

_____

_____

Present status and direction for continuity of care: _____

_____

_____

_____

☐ Check here if you have attached additional information

Name: _____ Signature: _____

Designation: _____ Phone #: _____

The reverse of this form must be completed each time a transferring officer, facility, hospital or health care provider accepts responsibility for the care of the person in custody being transferred, for example: 1) between a lock up and a police officer/sheriff;
2) between a correctional facility and a hospital.

All forms must accompany the person. Where applicable, attach this form to the warrant.

NAME OF RECEIVING FACILITY/HOSPITAL/TRANSPORTING AGENCY

Date of arrival: DD/ MM/ YYYY **Time of arrival:** ____________

Name of Transporting Agency

Name of Transporting Officer

Signature – Receiving Facility/Hospital

NAME OF RECEIVING FACILITY/HOSPITAL/TRANSPORTING AGENCY

Date of arrival: DD/ MM/ YYYY **Time of arrival:** ____________

Name of Transporting Agency

Name of Transporting Officer

Signature – Receiving Facility/Hospital

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