



# ISLAND HEALTH CARE TRANSFER FAX COVER SHEET

Facility: \_\_\_\_\_ Fax: \_\_\_\_\_

Date: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

From: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The following patient was recently transferred to your facility for inpatient treatment:

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

HH Physician: \_\_\_\_\_, notified \_\_\_\_\_.

Being treated at home by:  Nursing  PT  OT  ST  MSW  Dietician  HHA

For: \_\_\_\_\_  
\_\_\_\_\_

Patient has:  Living Will  Health Care Power of Attorney  DNR

Other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attached is a list of current medications.

**Please call THA Group at 912-233-2334 when patient is ready for discharge.**