



INTERHOSPITAL TRANSFER NOTIFICATION FORM

For use by Newfoundland and Labrador Regional Health Authorities as part of the
Interhospital Transfer Program

Phone Notification:

Hospital Name: _____ Caller Name: _____
(Shipping Site)

Hospital Name: _____ Receiver Name: _____
(Receiving Site)

Date: _____ Time: _____
yyyy-mm-dd hhmm

Fax Notification:

Fax To: (Receiving Site) _____

Fax #: (709) _____

Fax From: (Shipping Site) _____

Fax #: (709) _____

Sender's Initials: _____

Date of Notification: _____
yyyy-mm-dd

Mode of Transportation
(Document name of Carrier)

Air _____

Courier _____

Taxi _____

Other: _____
specify

Expected Date and Time of Arrival:

Date: _____
yyyy-mm-dd

Time: _____
hhmm

Notification received by: _____ Date: _____ Time: _____
(Receiving Site) yyyy-mm-dd hhmm

**Attach Fax Transmission Report to this Form
and attach to Copy of Interhospital Transfer Form**