PATIENT TRANSFER CHECKLIST
COVID-19 PATIENTS ONLY

TO BE COMPLETED BY SENDING PHYSICIAN OR CASE MANAGER
ALL AREAS MUST BE COMPLETED

Name: _____ DOB: ___/___/_____ Gender: _____

Address: _____ Phone: (____)_____-_____

Emergency Contact (Name, Relationship): _____

Emergency Contact Phone: (____)_____-_____

Insurance Provider: _____ Insurance ID Number: _____

Secondary Insurance (*if applicable*): _____ Insurance ID Number: _____

Current Treatment Provider: (*Name*)_____ (*Phone*): (___)_____-_____

Patient Location, Unit/ Floor:_____ Unit Phone Number:_____

Transfer Diagnosis: _____ Allergies: _____

Bed Type Requested (please circle or indicate): ICU/Telemetry/medical-surgical/other: _____

Primary Language: _____ Translation service needed? ☐ Yes ☐ No

Height (inches): _____ Weight: _____

Special Dietary Needs (if any): _____

SUBMIT THE COMPLETED PATIENT TRANSFER CHECKLIST AND HOSPITAL FACESHEET FOR REVIEW TO:

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
MEDICAL ALERT CENTER/TRANSFER CENTER
FAX 562-906-4300

FOR QUESTIONS, PLEASE CALL
PHONE (866) 940-4401

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