

Patient Name: _____
Medical Record Number: _____

Touro Infirmery Disaster Medical Assistance Team (DMAT) Transfer of Care Form

Attending Physician: _____ (please print) Date: _____

Contact Information (for use by DMAT only. Please indicate preferred method of contact):

Home phone _____ Cell phone _____

Office phone _____ Answering service _____

Beeper _____ E-mail _____

Active Medical Problems (consultants)

Inactive Medical Problems (consultants)

Brief Summary of Hospital Course

Code Status: _____

Current Medications – See attached medication reconciliation form

Allergies: _____

Plan of Care/Needs Prior to Discharge

Signature

Date

**IN THE EVENT OF A TRANSFER OR FOR PATIENT UPATE INFORMATION
PLEASE CALL: (888) TOURO-411**

