Canadian Paediatric Society

Copies of this form can be downloaded and printed from the CPS website at ***www.cps.ca***

Paediatric Transfer Record

TO DOCTOR

Address: _____

_____

Phone: _____

Fax: _____

e-mail: _____

PATIENT

Name: _____

Birth date: _____ ❑ M ❑ F

Address: _____

City/Province: _____ Postal code: _____

Health Card # _____

Mother/guardian: _____

Tel: Home _____ Work _____

Cell _____

Father/guardian: _____

Tel: Home _____ Work _____

Cell _____

Child lives with: _____

Will an interpreter be required? ❑ Yes ❑ No Language _____

FAMILY BACKGROUND: Occupation/Medical history

Mother: _____

Father: _____

Siblings: _____

Other family household history: _____

_____

_____

_____

_____

BIRTH AND NEONATAL HISTORY

Gestational age: _____ Weight: _____

Height: _____ Apgar (score): _____

Comments: _____

_____

_____

_____

LAST EXAMINATION IN THIS OFFICE

Date: _____

Age: _____ School grade: _____

Height: _____ Weight: _____ BMI: _____

BP: _____ ❑ Growth curves enclosed

Comments: _____

_____

_____

_____

MEDICAL/SURGICAL HISTORY: Significant illnesses

No.	Problem	Date(s)	Subspecialist consulted	Treatment/Outcome
1.				
2.				
3.				
4.				

.../over

MEDICAL/SURGICAL HISTORY: Significant illnesses *(cont'd)*

No.	Problem	Date(s)	Subspecialist consulted	Treatment/Outcome
5.				
6.				
7.				

CURRENT MEDICATIONS: _____

_____

_____

_____

CURRENT CONSULTATIONS/INVESTIGATIONS

_____

_____

_____

KNOWN OR SUSPECTED ALLERGIES: (include medications)

_____

_____

Vaccines	Date	Date	Date	Date	Date	Date	Date
DTap/IPV Hib							
PC							
MC							
MMRV							
MMR							
V							
Hep A							
Hep B							
Td or dTap							
Influenza							
HPV							
Rotavirus							
Others:							

Signed: _____

Print name: _____

Address _____

_____

Phone: _____ Fax: _____

Date: _____

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July 2010