SHARED TRANSFER OF CARE

Shared Information Record (Page 1 of 2)

NAME			DOB
DOCTOR			UR
HEALTH PROFESSIONAL/ ORGANISATION (add contact name and details)	DETAILS OF HOW TRANSFER OF CARE PLAN WAS COMMUNICATED		
	DATE AND TIME	COMMUNICATION METHOD (I.E. EMAIL AND FOLLOW-UP CALL)	SERVICE CONFIRMED AND ADDED TO TRANSFER PLAN
Coordinator of Care (Transfer planner) CONTACT NAME			
My Aged Care Gateway CONTACT NAME			
Community Case Manager CONTACT NAME			
Community Nurse (inc. area/service) CONTACT NAME			
Post-acute Package CONTACT NAME			
Pharmacist CONTACT NAME			
Other Services CONTACT NAME			
Other Services CONTACT NAME			
Other Services CONTACT NAME			

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GENERAL PRACTITIONER			
GP Name			
Practice			
Address			
Phone			
Fax			
GP Notified of transfer plan?	☐ Yes	☐ No	
Date Notified			
Method of notification	☐ Fax ☐ Scan/Email ☐ Post ☐ Telephone		
Follow-up appointment made and included in plan?	☐ Yes	☐ No	
ADDITIONAL INFORMATION PROVIDED TO PERSON BEING TRANSFERRED			
Information brochures given and explained?	☐ Yes	☐ No	
Provided with transfer plan?	☐ Yes	☐ No	

SIGNATURE OF PERSON BEING TRANSFERRED	
I understand the plan given to me and have had the opportunity to have my questions answered and clarified.	

SIGNATURE OF COORDINATOR OF CARE	
I have given a copy of the plan to the person being transferred, and to the relevant services as documented on this form.	