Republic of Lebanon – Ministry of Public Health

Transfert Request Form

A. From 1st Hospital

Date		Clinician Name	
Hospital Name		Phone Name	

B. Patient Identification

First Name		Gender	
Family Name		Nationality	
Date of Birth		ID Number	

C. Prior Medical Conditions

Underlying Conditions	☐No, ☐Yes, specify:
Chronic Treatment	☐No, ☐Yes, specify:

D. Illness

Date onset				
Symptoms	☐ Fever /history of fever	☐ Nasal discharge	☐ Dyspnea	
	☐ Coughing	☐ Sore Throat	☐ Other:	
Severity	BP S/D:	WBC count:	pH:	Chest XR:
	HR/mn:	Lymphocytes:	PaO_2:	
	RR/mn:	Flu rapid test:	$PaCO_2$:	
	Sat O_2 :	Flu PCR:	HCO_3^-:	
	Glasgow:		Sat O_2:	

E. Exposure to COVID-19 (in 14 days prior to onset)

Travel	☐ No ☐ Yes, specify	Country:	Date of arrival:
Link with covid19 case	☐ No ☐ Yes, specify	Name:	
Professional activity	☐ No ☐ Yes, specify	Profession:	Institution:
Social network	☐Contact with travelers	☐High contact with people	☐Social event/mass gathering

F. Case management at 1st hospital

Date of admission	
Diagnosis	
Treatment	
Mechanical ventilation	☐ No ☐ Yes, specify type:
Isolation	☐ No ☐ Yes, specify starting date:
ICU	☐ No ☐ Yes, specify starting date:
Outcome	Responsive to antibiotics: ☐ No ☐ Yes

G. For RHUH

Criteria assessment		
Transfer clearance	☐ Transfer	☐ Non transfer
Nb of specimens need		

H. Notes