**Inpatient expectations: Transfers**

To ICU:

1. When transferring a patient to the ICU, the ICU senior (5-1088) should have been notified early in the process. It is okay to call and "give a heads up" for the MICU team to be aware of a patient that is gradually or steadily worsening. They keep track of these patients with a "hot list". If it is an emergent transfer it is okay to have a nurse or other care team member call if you are taking care of an immediate need for the patient.
2. You should be available and at the bedside when the MICU senior or team member comes to evaluate the patient. This is your patient and you know them better than any other healthcare team member in the hospital. Please practice giving succinct presentations (10-20 seconds) in emergent situations. Further details can be added after the initial presentation as the team evaluates the patient (high K today, didn't wear CPAP, got dilaudid in ED, etc).
3. If the ICU team decides they are going to the ICU then they will take care of the orders. At this time you can give a more complete summary to the intern or resident that will take the patient or just ask if they need any more information from you.

From ICU:

1. When a patient is being called out from the ICU, first check to make sure it should be a family medicine team patient, listen to the story, ask for any further information you may need, then add the patient to the census.
2. The ICU resident will have an off-service note within 24 hours which summarizes the care the patient received during the ICU stay. If you are doing your accept note the same day it is appropriate and encouraged to contact the ICU resident via phone for a verbal hand-off (call the senior or have your team leader locate the resident's pager). Please notify your team leader if no off-service note is written.
3. The accept note is basically the consult template changed to "Accept note" which should include a brief summary of the hospital course thus far, along with the full history, physical and plan.
4. You should review the orders and delete any that are no longer necessary (often patients will have a daily CXR, daily CBC with differential, continuous monitoring, etc).

To Rehab or Psych:

1. When transferring a patient to rehab, the social worker or case manager usually writes a note or calls when the patient has been accepted. For psychiatry transfers you will usually be in touch with the psychiatrist or nurse manager on 6W. You may then publish your discharge summary ASAP (must be completed within 24 hours).
2. Complete the medication reconciliation and enter a discharge order (discharge to TCH rehab or behavioral/psych).

3. Rehab or psychiatry will then complete the discharge-readmit by saving orders, etc.

From Psych/Rehab:

1. When accepting a patient from psychiatry or rehab you will generally not have an off-service note, but a discharge summary will be published at some point (may not be prompt). Please complete an accept note similar to the ICU accept note (include brief summary of reason for admission, hospital course, and reason for transfer along with H&P, assessment and plan).
2. First, make sure the medication reconciliation has been completed by the primary team (rehab or psych). If not, please contact them to make sure this will be done.
3. Before the patient is transferred, go to the discharge-readmit navigator (under more activities tab) and save current orders for admission (see tip sheet).
4. If you are reviewing orders after the patient has already been transferred you cannot use the discharge-readmit navigator and will just need to enter orders from scratch using the direct admit tab.