

**Health Information Transfer Form**

*Pursuant to 95(1) (b) of the Correctional Services Act, sharing health information is necessary to ensure safety and continuity of care of a person in custody.*

**SECTION A MUST BE COMPLETED BY**

- a) if the transfer originates at a facility or hospital, a representative of the facility or hospital;
- b) if the transfer does not originate at a facility or hospital, the transferring officer.

Name of person in custody: \_\_\_\_\_  
 Health card number (if known): \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Next of kin: \_\_\_\_\_ Telephone number: \_\_\_\_\_

**SECTION B MUST BE COMPLETED BY THE TRANSFERRING OFFICER.**

Conditions requiring ongoing attention:  
 aggression towards others       potential for self harm       health issues

Statement of health status as observed by officer or reported by person in custody:  
 \_\_\_\_\_  
 \_\_\_\_\_

Assessed and/or treated by health care provider:       yes       no  
**(If yes health care must complete section D.)**

Reasons for arrest \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Designation: \_\_\_\_\_ Phone#: \_\_\_\_\_

**SECTION C MUST BE COMPLETED BY A REPRESENTATIVE OF A FACILITY OR HOSPITAL.  
 (applies if the transfer originates at a facility or hospital)**

- Conditions requiring ongoing attention:
- aggression towards others       potential for self harm
  - epilepsy       high blood pressure       alcohol/drug seizures       heart problems
  - diabetes       suicidal thoughts       Contact lenses       other prosthesis
  - breathing problems       orthodontic appliances
  - infectious disease (if required, please attach list of additional precautions for client, escorting and facility staff )

Medications (if known)

Medication	Dose	Frequency	Time last administered

Medications transferred with person in custody?     Yes       No  
 Known allergies: \_\_\_\_\_

Upcoming appointments (if known): \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Designation: \_\_\_\_\_ Phone#: \_\_\_\_\_

**SECTION D MUST BE COMPLETED HEALTH CARE PROVIDER.  
 (applies if the person in custody being transferred receives care or treatment from a health care provider)**

Principal/provisional diagnosis (physician only): \_\_\_\_\_

Treatment provided: \_\_\_\_\_

Present status and direction for continuity of care: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Designation: \_\_\_\_\_ Phone #: \_\_\_\_\_

The reverse of this form must be completed each time a transferring officer, facility, hospital or health care provider accepts responsibility for the care of the person in custody being transferred, for example: 1) between a lock up and a police officer/sheriff;  
 2) between a correctional facility and a hospital.

All forms must accompany the person. Where applicable, attach this form to the warrant.

**RECEIVING FACILITY/HOSPITAL**

**Date of arrival:** DD/ MM/ YYYY

**Time of arrival:**\_\_\_\_\_

\_\_\_\_\_  
Signature - Receiving Facility/Hospital

**RECEIVING FACILITY/HOSPITAL**

**Date of arrival:** DD/ MM/ YYYY

**Time of arrival:**\_\_\_\_\_

\_\_\_\_\_  
Signature - Receiving Facility/Hospital

**RECEIVING FACILITY/HOSPITAL**

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\_\_\_\_\_  
Signature - Receiving Facility/Hospital

**RECEIVING FACILITY/HOSPITAL**

**Date of arrival:** DD/ MM/ YYYY

**Time of arrival:**\_\_\_\_\_

\_\_\_\_\_  
Signature - Receiving Facility/Hospital