Transfer to PCCE Application

It is Mandatory for acceptance to fill this form and email to: hos-pcce@kau.edu.sa

Patient's name:
Birth date:
Nationality:
Sex:
Hospital:
Medical number:
Referring Consultant:
Phone number for contact:
E-mail address of referring physician:
Date of admission:
Diagnosis:

Last Echo Report Summary:

Current condition

Neurological examination:
Cardiac examination:
Chest examination:
Abdominal examination:
Limbs examination:
Input (entral and parental) versus output (urine) and balance:

Current Ventilatory Status

Mechanically ventilated (Y/N)?	Settings:
CPAP (Y/N)?	Settings:
BiPAP (Y/N)?	Settings:
Nasal cannula (Y/N)?	O2 flow:
Face mask (Y/N)?	O2 flow:
Non re-breathing mask (Y/N)?	O2 flow:
Off Oxygen (Y/N)?	

Last investigations

CBC (within last 2 days)			
WBC:	Hb:	Htc:	Plat:
Lymp%:	Staff%:	Seg%:	Bands%:

CRP (within last 2 days):
ESR (within last 2 days):

U&E

Urea: mmol/L	Creat: mmol/L	Na: mmol/L
K: mmol/L	Ca: mmol/L	Mg: mmol/L

LFT (if possible)

Bit T: µmol/L	Bil D: µmol/L	
ALT: u/L	AST: u/L	GGT: u/L
T protein: g/L	Albumin: g/L	

Cultures

* Blood ***(Mandatory for all cases, within last 3 days)***:	Central/Peripheral:	Organism:
Respiratory:	ET tube suction/nasopharyngeal:	Organism:
Urine:	Catheter/voiding sample:	Organism:
Swab:	(Source):	Organism:

Current medications

-Infusions:

PGE2	**Dose**	**Duration**
Inotropes	**Dose**	**Duration**

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-
-

-Antibiotics:

Name	**Dose**	**Duration**

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-
-

-Others

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Referring consultant signature:

Date: