



Evaluation of the Inter-Hospital Patient Transfer Form (Health 946): A Perception Study of Medical Officers in Base Hospital Kalmunai North, Sri Lanka

Safiudeen T¹, Baminy N²

¹Base Hospital, Kalmunai North, ²Postgraduate Institute of Medicine, University of Colombo

Correspondence to:

Safiudeen T

E-Mail

thahira.sl@gmail.com

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Abstract

Background: Effective communication during patient handovers is critical to ensuring continuity of care and patient safety. International evidence consistently identifies communication failures as a leading contributor to preventable adverse events. In Sri Lanka, Health Form 946 (H946) has served as the nationally mandated document for inter-hospital patient transfers for several decades. However, its alignment with contemporary structured communication standards has not been systematically evaluated.

Objective: This study aimed to assess the perceptions of Medical Officers (MOs) regarding the adequacy of H946 for supporting safe and effective inter-hospital patient transfers, focusing on information content, layout, ease of use, and implications for clinical safety.

Methods: A descriptive cross-sectional study was conducted in September 2025 at Base Hospital Kalmunai North (BHKM). All currently employed MOs were included. Data was collected using a structured, validated, self-administered questionnaire comprising Likert-scale and open-ended questions across four domains: demographics and usage, information content, layout and usability, and key recommendations.

Results: Seventy-eight percent of MOs reported using H946 two to three times per week. While 93% agreed that the form adequately captures basic patient identification, only 13% felt it clearly prompts documentation of the precise reason for transfer, and 91% reported insufficient space for a comprehensive clinical summary. Ninety-seven percent strongly disagreed that the form mandates inclusion of critical safety information such as allergies and current medications, and 92% found it ineffective in preventing documentation errors or omissions. Eighty-one percent supported integration of a structured checklist, and 77% believed a redesigned form would reduce patient risk during transfer.

Conclusion: The findings demonstrate that while H946 fulfils its administrative role, it does not adequately support the structured clinical communication required for safe inter-hospital patient handover. A revised form incorporating internationally recommended structured handover elements would represent a meaningful, system-level patient safety improvement.

Introduction

The safe transfer of patients between clinical settings is one of the most vulnerable transitions in the continuum of care. When a patient is moved from one institution to another, clinical responsibility is formally handed over and any failure in communication or documentation can result in delays in treatment, duplication of investigations, inappropriate clinical decisions, or direct patient harm. Consequently, inter-hospital patient transfer is widely recognized as a high-risk process requiring meticulous coordination

and clear, structured communication.

Globally, communication failure during clinical handovers has been identified as a leading cause of preventable adverse events. Data from the Joint Commission (USA) consistently identified communication breakdowns as the most frequent root cause of sentinel events [1]. Australian patient safety evidence has demonstrated that a substantial proportion of hospital adverse events, including those resulting in death or permanent disability, are attributable to system-level communication failures rather than individual clinician error [3].

Building on this evidence, the Australian Commission on Safety and Quality in Health Care has identified ineffective communication during clinical handover and patient transfer as a major contributor to preventable patient harm [4].

High-reliability industries such as aviation and nuclear power have long demonstrated the value of structured, standardized communication frameworks to minimize error. Healthcare has adopted similar principles through structured handover tools such as ISBAR (Introduction, Situation, Background, Assessment, Recommendation) and I-PASS (Illness Severity, Patient Summary, Action List, Situation Awareness and Contingency Planning, Synthesis by Receiver). International bodies, including the World Health Organization (WHO) and the Joint Commission, strongly advocate structured written and verbal handovers as essential components of safe patient transfer [1, 5, 6].

Transfer documentation serves multiple purposes: it provides a clinical summary, authorizes the transfer, and enables the receiving team to establish immediate continuity of care. Effective documentation must systematically address the clinical reason for transfer, current clinical status, pre-transfer stabilization, communication with the receiving institution, and clear accountability to prevent avoidable adverse outcomes [6, 7].

In Sri Lanka's government health system, inter-hospital patient transfers are documented using Health Form 946 (H946), titled "Transfer of Patients from One Institution to Another." This trilingual form has been in use for several decades and includes sections on institutional details, patient demographics, basic clinical information, and transferring officer details. Its longstanding use has promoted a degree of uniformity across hospitals; however, as patient safety standards and structured communication practices have evolved internationally, it is both timely and necessary to evaluate whether H946 continues to meet the requirements of contemporary clinical care, particularly for high-acuity transfers requiring comprehensive, structured handover communication.

Justification

Health Form 946 (H946) is the only mandated transfer document used across all government hospitals in Sri Lanka, making the adequacy of its design a matter of national patient safety concern. The form has served an important administrative function for many years, and its trilingual format has contributed to consistency

across a diverse health system. However, as international patient safety standards have advanced considerably since H946's introduction, it is important to assess whether the form continues to meet the clinical communication needs of modern patient transfers.

A critical examination of H946 reveals that the form does not contain structured fields for several categories of clinical information that are internationally recognized as essential for safe handover. The form currently lacks dedicated sections for: the precise clinical reason for transfer; a comprehensive clinical summary; known allergies and current medications; pre-transfer stabilization measures taken; informed consent for transfer; confirmation of bed or specialist availability at the receiving institution; the urgency of transfer; provisional diagnosis; and the direct contact details of the transferring clinician. In the absence of structured prompts, documentation relies entirely on unstructured free-text narrative, an approach known to increase the likelihood of information omission and inconsistency, particularly in high-workload clinical environments where time pressure and cognitive load are considerable.

These gaps carry direct implications for patient outcomes. Omission of allergy or medication information can precipitate avoidable adverse drug events. An unclear or absent reason for transfer delays triage and clinical decision-making at the receiving institution. The absence of the transferring clinician's contact details removes an important safety net for clarification when clinical questions arise after handover. From a patient safety perspective, these represent latent, system-level vulnerabilities rather than individual failures, consistent with the principles of the Swiss Cheese Model, where multiple systemic weaknesses can align to produce adverse events.

Despite the widespread daily use of H946, no published study has systematically evaluated its effectiveness or explored the perceptions of clinicians who use it. Medical Officers, as the primary users of this form, are uniquely positioned to identify its practical limitations and to describe which categories of clinical information are most frequently missed or difficult to communicate. This experiential perspective provides a credible, evidence-based foundation for reform.

The findings of this study will serve several

specific purposes for the Ministry of Health and relevant policymakers. First, they will provide empirical, clinician-generated evidence on the structural and clinical deficiencies of H946, translating practical experience into a data-driven case for form revision. Second, by identifying which categories of clinical information are most frequently inadequately documented, the findings will guide prioritization of mandatory structured fields in a revised form. Third, the study generates evidence on the acceptability of a structured checklist approach among frontline clinicians, which directly supports the case for adopting an internationally aligned handover framework. In this way, the study makes a direct contribution to patient safety policy, clinical governance reform, and the improvement of inter-hospital transfer communication within Sri Lanka's public health system.

Literature Review

Communication Failures During Patient Handover: Global Evidence

Clinical handover is recognized internationally as a critical component of patient safety and clinical governance. Communication failures during patient transfers contribute substantially to preventable adverse events, including medication errors, delayed treatment, duplication of investigations, prolonged hospital stays, readmissions, and sentinel events [1–4]. In response, the World Health Organization (WHO) identified communication during patient handovers as one of its nine Patient Safety Solutions and recommends standardized handover tools, uninterrupted communication, read-back procedures, inclusion of essential clinical information (patient status, medications, treatment plans, and advance directives), and formal training in handover practices to improve the safety and continuity of care [5]. Similarly, the Joint Commission has consistently emphasized standardized communication as a National Patient Safety Goal to reduce preventable harm associated with ineffective handovers [6].

Beyond communication frameworks, qualitative research involving key stakeholders has consistently highlighted that transfer documents should be concise, user-friendly, logically organized, and focused on current and clinically relevant information, with person-centred details prominently presented to facilitate rapid clinical decision-making [14–16]. Common deficiencies in poorly designed transfer documents include inadequate space

for clinical reasoning, omission of allergy and medication history, absence of pre-transfer stabilization checklists, and insufficient documentation of accountability through identifiable transferring clinicians [17]. A recent review of verbal and written handovers in complex healthcare settings concluded that non-standardized communication increases the risk of losing critical patient information during transitions of care [13].

Structured Handover Tools: Design, Application, and Evidence Across Clinical Settings

Structured communication frameworks have become the international standard for improving the quality and safety of patient handovers across diverse clinical settings. The most widely adopted tools differ in their design emphasis and target environments, but share the principle of systematic, prompt-guided communication to ensure that essential clinical information is consistently transferred.

ISBAR (Introduction, Situation, Background, Assessment, Recommendation) is one of the most widely implemented handover frameworks globally. Originally adapted from military communication protocols, ISBAR is used across a broad range of settings including emergency department (ED) escalation to senior clinicians, nursing shift-change handoffs in general medical and surgical wards, ward-to-ward patient transfers, and ICU-to-ward transitions. Its brevity and logical sequencing make it particularly effective in time-pressured environments where communication must be concise yet comprehensive [7].

I-PASS (Illness Severity, Patient Summary, Action List, Situation Awareness and Contingency Planning, Synthesis by Receiver) was originally developed and validated in paediatric inpatient settings, where structured handovers were shown to significantly reduce medical errors and adverse events. The framework has since been extended to adult acute medical and surgical wards, where it has demonstrated similar improvements in handover completeness and patient safety outcomes. Its inclusion of a synthesis step, where the receiving clinician verbally confirms understanding, strengthens communication reliability [7].

IMIST-AMBO (Identification, Mechanism/Medical Complaint, Injuries/Information, Signs and Symptoms, Treatment and Trends, Allergies, Medications, Background, Other Information) was designed specifically for pre-

hospital to emergency department handovers in paramedical and trauma settings. Its inclusion of dedicated fields for allergies, medications, and relevant background history makes it particularly relevant for the transfer of acutely ill or injured patients where medication-related safety information is critical [7].

ICU-PAUSE was developed to address the specific communication demands of intensive care unit to ward transitions, where clinical complexity, medication burden, and the risk of information loss during transfer are highest. The tool standardizes documentation and verbal communication through a structured format that prompts systematic multidisciplinary review. Pilot implementation demonstrated improved communication quality and reduced safety concerns during ICU-to-ward transfers [18].

In nursing-specific contexts, a systematic review by Bukoh and Siah [20] demonstrated that standardized handover formats applied during nursing shift changes effectively reduced omission of information, inaccurate communication, and documentation errors, thereby improving patient safety. Structured surgical handover tools, such as that developed by Din et al. [19], have similarly improved the completeness of clinical information during peri-operative handoffs, demonstrating the generalizability of structured approaches across surgical ward settings.

McCarthy et al. [21], in a systematic review evaluating structured handoff protocols across acute care hospitals, reported that standardized tools — particularly I-PASS and SBAR — probably improve patient safety outcomes, with I-PASS demonstrating the strongest quality of evidence. Murray et al. [12] showed that a structured stroke patient transfer checklist reduced the median hospital length of stay, while Nathan et al. [11] demonstrated that a standardized transfer process in a neuro-intensive care unit significantly reduced clinician concerns regarding patient safety during transitions. Collectively, these findings confirm that structured handover tools are effective across emergency, critical care, paediatric, surgical, and general ward settings; the specific design of each tool should, however, be tailored to the clinical context in which it will be used.

Patient Transfer Documentation in Sri Lanka: Policy Framework and Practice Gaps

Within the Sri Lankan government health system, inter-hospital patient transfers are

mandated through Health Form 946 (H946) in accordance with Ministry of Health General Circular 01-09/2002. The circular specifies that the transfer form should clearly document the reason for transfer, the expected intervention at the receiving institution, and the anticipated prognostic benefit, while duplicate copies should be retained for institutional records. Although the circular emphasizes the importance of comprehensive documentation, H946 was developed before the widespread adoption of contemporary patient safety principles and structured communication practices in healthcare.

Emerging local evidence points to important gaps between the policy intent and actual documentation practice. A study conducted at a District General Hospital in Sri Lanka identified specific deficiencies in transfer documentation and recommended revision of the existing transfer form to improve communication between referring and receiving institutions [8]. A further evaluation at District General Hospital Embilipitiya highlighted the urgent need for standardized transfer protocols, improved documentation practices, and strengthened communication pathways to ensure safer patient transfers [9]. Similarly, a descriptive analysis of paediatric transfer forms at Teaching Hospital Anuradhapura found that the reason for transfer was absent in nearly one-third of forms, illustrating the magnitude of incomplete documentation in routine clinical practice [10].

Taken together, these findings indicate that the current application of H946 does not consistently achieve the documentation standards outlined in the Ministry of Health circular, and that the structural design of the form may itself contribute to these shortfalls. As the volume and complexity of inter-hospital transfers increases, particularly in the context of a healthcare system managing a significant burden of non-communicable disease, the need for a structured, evidence-aligned transfer document in Sri Lanka is both timely and pressing.

Methodology

Study Design and Setting

This was a descriptive cross-sectional study conducted at Base Hospital Kalmunai North (BHKN) in Sri Lanka during September 2025. BHKN is a Type A Base Hospital with a bed strength of 413, serving an average daily outpatient population of approximately 450, and providing specialist services across

Medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, Ophthalmology, and Psychiatry, supported by 13 consultants. This setting is highly representative of a secondary care government hospital and serves as a frequent site for both inward and outward inter-hospital patient transfers, making it an appropriate context for this evaluation.

Study Population and Sampling

The study population comprised all Medical Officers (MOs) currently employed at BHKN in September 2025. All MOs actively working in the hospital during the study period were included. MOs on maternity leave, long-term sick leave, or overseas leave were excluded as they were not actively involved in patient transfer documentation. The final eligible sample consisted of 84 MOs.

Study Instrument Development and Validation

The data collection instrument was developed through a systematic, multi-stage process grounded in the international patient safety literature. In the first stage, a structured review of evidence-based guidelines and peer-reviewed literature on clinical handover and inter-hospital patient transfer was conducted, drawing on recommendations from the World Health Organization (WHO) Patient Safety Solutions, Joint Commission National Patient Safety Goals, and published studies on structured handover documentation. This review identified the key dimensions of safe transfer communication that should be assessed, including information content, structural design, ease of use, and clinical safety function.

In the second stage, a preliminary item pool was developed encompassing four thematic domains: (A) Demographics and Usage Frequency, to characterize the respondent's role and frequency of interaction with H946; (B) Information Content, assessing whether H946 adequately captures clinically critical data elements required for safe handover; (C) Layout and Ease of Use, evaluating the structural design, language clarity, and usability of the form; and (D) Key Recommendations and Improvement Suggestions, to elicit narrative proposals from clinicians for form enhancement. Domains B and C were operationalized using a five-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). Domain D comprised structured open-ended questions.

Content validity and face validity of the instrument were then established through an

expert panel review. The panel comprised the Hospital Director, a Consultant Paediatrician, a Consultant Physician, and the Medical Officer In Charge of the Quality Management Unit — collectively representing expertise in hospital administration, clinical medicine, paediatric care, and clinical quality improvement. Each panellist independently reviewed all items for relevance, clarity, domain alignment, and adequacy of coverage. Feedback from this review informed targeted revisions to item wording and sequencing, ensuring that the final questionnaire adequately captured the dimensions of H946's performance in routine clinical practice.

Data Collection and Analysis

The validated questionnaire was administered in September 2025 via Google Forms. The survey link was distributed to all eligible MOs through WhatsApp and institutional email. Reminder messages were sent at regular intervals to maximize the response rate. Responses from Domains B and C were analysed using descriptive statistics, with results reported as percentages and frequencies to characterize the distribution of agreement and disagreement with each statement. Responses from the open-ended questions in Domain D were analysed thematically, with recurring suggestions grouped into thematic categories to identify the most frequently reported areas of deficiency and priority recommendations.

Results

Usage Frequency (Section A)

Approximately 78% of Medical Officers working in the clinical wards reported completing or encountering H946 for patient transfers (both transfer-in and transfer-out) two to three times per week. Medical Officers based in the blood bank and laboratory did not provide responses, as they are not routinely involved in patient transfer documentation.

Perception of Information Content (Section B)

Medical Officers' perceptions of H946 revealed considerable variation in the form's ability to capture critical patient information. Ninety-three percent agreed or strongly agreed that patient identification details are sufficiently covered. However, only 13% agreed that the form adequately captures the precise reason for transfer, and only 9% considered the space provided for a full clinical summary to be sufficient.

Only 3% of MOs agreed that the form mandates documentation of allergies and current medications, with 97% strongly disagreeing. An identical pattern was observed for consent documentation, where only 3% agreed that informed consent is clearly required on the form, with 97% strongly disagreeing.

Perception of Layout and Ease of Use (Section C)

Eighty percent of MOs agreed that the overall layout of H946 is logical. However, only 8% agreed that the current design helps prevent documentation errors or omissions, with 92% disagreeing. Notably, 81% agreed that inclusion of a structured checklist would significantly improve the utility and reliability of the form.

Key Recommendations (Section D)

Thematic analysis of open-ended responses reinforced the quantitative findings. The most frequently recurring suggestions were: a more structured clinical summary section; a dedicated field for the specific expected intervention at the receiving hospital; and inclusion of the contact details and designation of the transferring officer to facilitate direct communication when needed. Nearly 77% of MOs indicated that an improved, redesigned transfer form would significantly reduce patient risk during transfer.

Discussion

This study demonstrates that while H946 is perceived by Medical Officers as adequately fulfilling its administrative function of documenting inter-hospital patient transfers, it does not provide the structured clinical communication framework necessary to ensure safe patient handover. These findings are consistent with international patient safety recommendations, which affirm that effective transfer documentation must facilitate the complete, accurate, and standardized exchange of clinical information [5, 6]. At the same time, this study builds directly on the local evidence base, confirming within a well-defined institutional context the documentation gaps that have been reported in earlier Sri Lankan studies [8–10].

The most prominent finding was the perceived inadequacy of H946 in capturing the clinical reason for transfer and providing sufficient space for a comprehensive clinical summary. This is consistent with local studies reporting that the reason for transfer was absent in nearly one-third of paediatric transfer forms [10], and with evaluations at District General Hospital

Embilipitiya and other institutions that identified deficiencies in transfer communication between referring and receiving hospitals [8, 9]. Internationally, Kuncze et al. [13] similarly concluded that non-standardized handover documents increase the risk of losing critical patient information during transitions of care. The consistency of this finding across different health systems and clinical settings underscores that free-text documentation, without structured prompts, is an inherently limited approach to handover communication.

The near-universal disagreement that H946 adequately documents safety-critical elements — including allergies, current medications, and informed consent — is of particular concern. These findings align closely with international literature identifying omission of medication history, allergy status, and pre-transfer stabilization details as major contributors to communication-related patient safety incidents [17]. The WHO Patient Safety Solutions explicitly identify these elements as essential components of safe clinical handover [5], and each of the leading structured handover tools addresses them systematically: IMIST-AMBO dedicates specific fields to allergies and medications; I-PASS includes contingency planning and an action list; and ISBAR requires explicit documentation of assessment findings and recommendations. The current design of H946 does not embed these prompts, placing the burden of recall entirely on the individual clinician.

An important and somewhat counterintuitive finding was the contrast between familiarity and safety. While 80% of respondents considered the overall layout of H946 to be logical and easy to use, only 8% believed that the design helps prevent documentation errors. This dissociation between perceived usability and patient safety function is significant: familiarity with a form should not be conflated with its clinical effectiveness. Similar observations have been reported in quality improvement literature, where redesigning transfer documents using structured checklists significantly improved completeness and reduced communication failures, even when the original forms were considered user-friendly by clinical staff [11, 12, 18, 19]. The findings of the present study are consistent with these reports and suggest that clinicians recognize the limitations of familiarity-based practice when patient safety is considered explicitly.

The strong endorsement of a structured checklist by more than four-fifths of respondents provides direct empirical support for redesigning H946 along structured handover principles. This finding is not merely an expression of preference; it reflects frontline clinical awareness of a process deficiency. When compared against the design features of validated tools such as ICU-PAUSE [18], the surgical handover tool by Din et al. [19], and nursing-specific structured formats evaluated by Bukoh and Siah [20], H946 displays several structural gaps: the absence of itemized safety prompts, the lack of a checklist format to guide pre-transfer preparation, no designated accountability section for the receiving clinician, and no mechanism for confirming two-way communication between institutions. These are not peripheral design details; they are core features that distinguish documentation systems capable of supporting safe handover from those that merely record a transfer has occurred.

From a systems perspective, the deficiencies identified in H946 are best understood as structural vulnerabilities rather than individual failures. The Swiss Cheese Model of accident causation is instructive here: each documentation gap represents a layer with a potential hole through which errors can pass undetected. When multiple gaps co-exist — absent allergy information, unclear reason for transfer, no contact details for the transferring clinician — the cumulative risk of preventable harm during transfer increases substantially. Strengthening the structure of H946 by embedding internationally recommended safety elements addresses these vulnerabilities at the system level, rather than relying on the memory and diligence of individual clinicians under time pressure.

The recommendations provided by Medical Officers in this study closely align with the design principles of validated structured transfer documents described in the international literature [14–16], including logical sequencing, concise presentation of essential clinical information, clear accountability mechanisms, and user-friendly layouts. Since H946 is mandated nationally, revising it to incorporate these evidence-based elements would represent a system-level patient safety intervention with the potential to benefit every inter-hospital transfer in Sri Lanka's government health system.

Conclusion and Recommendations

This study evaluated Medical Officers' perceptions of Health Form 946 (H946) at Base Hospital Kalmunai North and identified important areas where the form could be strengthened to better support safe inter-hospital patient handover. The findings can be grouped into three conceptual domains.

Clinical Content Deficiencies. Medical Officers consistently identified that H946 does not facilitate adequate documentation of essential clinical information. Key omissions include the precise reason for transfer, a comprehensive clinical summary, known allergies and current medications, informed consent, pre-transfer stabilization measures, and the expected intervention at the receiving institution. These gaps reflect structural limitations of the form rather than individual documentation failures.

Structural and Process Weaknesses. Although respondents were generally familiar with the layout of H946 and considered it logical, most believed its design does not prevent documentation errors or omissions. The reliance on unstructured free-text narrative, the absence of safety-oriented prompts and checklists, and the lack of a mechanism for documenting two-way communication with the receiving institution represent process deficiencies that increase the risk of incomplete handover. When compared to internationally validated structured tools, H946 lacks the systematic prompting that underpins safe and consistent clinical communication.

Stakeholder Support for Structured Reform. Medical Officers expressed strong and consistent support for a redesigned, structured transfer document. The overwhelming endorsement of a structured checklist format and the recognition that a redesigned form would reduce patient risk reflect both clinical need and readiness for change. This consensus among frontline clinicians provides an important mandate for policy action.

Based on these findings, the following recommendations are proposed:

Initiate a national review of Health Form 946 in consultation with the Ministry of Health and relevant clinical stakeholders, with the aim of evaluating its adequacy against current international patient safety standards for inter-hospital patient transfer.

Introduce mandatory structured fields for patient safety-critical information, including the precise reason for transfer, a comprehensive

clinical summary, known allergies, current medications, pre-transfer stabilization measures taken, informed consent documentation, and confirmation of receiving institution readiness.

Strengthen accountability and communication by incorporating designated fields for the name, designation, and direct contact details of the transferring Medical Officer, facilitating timely clarification and continuity of care between institutions.

Support the introduction of any revised form with structured training for Medical Officers and Intern Medical Officers in evidence-based clinical handover communication, accompanied by regular documentation audits to monitor compliance and promote continuous quality improvement.

Conflict of Interest

There is no conflict of interest. The authors did not receive any financial or other support from any organization or individual that could have influenced the outcome of this study.

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