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Policy/Plan for Planned Patient Transfer from Pediatric to ACHD Care

Date Effective: MM/DD/YYYY
Type of Policy: Please indicate if this document is **hospital policy or ACHD program policy/clinical guideline.**

Purpose

Indicate why this policy is in place and the population it benefits.

Policy Statement

State the actual policy for planned patient transfer from the pediatric to ACHD Care. This statement can be a brief overview of the policy, but please reference the age or age range at which this transition occurs.

Procedures

Describe the specific process and steps that occur throughout the transition process. Include details such as:

- Detailed timelines of the transition process from pediatric to ACHD care
- The name of the facility to which these patients are transferred
- ACHD team members involved in transition process
- Transition readiness assessment tools utilized by your institution
- Methods to manage ACHD patients after initial transition

References

If applicable, please list any articles or other resources utilized to develop your institution's policy for planned patient transfer from pediatric to ACHD care.

Required Signatures

This document requires signatures from specific personnel. Please note that we require signatures from **ALL** individuals listed below in order for the document to be valid:

- Medical Program Director of ACHD
- Transition Nurse Coordinator
- Chief of Pediatric Cardiology

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Helpful Tips

Please upload any documentation or examples of the above policy to the "additional files" section of your application.

Section K: Transitional Services. These documents should be labeled with "**K2"** only in the title so that each policy/plan can be easily identified.