Name of Transferring Health Care Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Medical Treatment and Labor Act - EMTALA

This hospital is required by federal law to provide any presenting patient with a medical screening examination to determine whether an emergency medical condition exists and to provide necessary stabilizing care within its capabilities for emergency medical conditions, without regard to means or ability to pay. This hospital participates in Medicare and Medicaid.

Upon completing this form make 3 copies and distributed as follows: One to Patient, One to Receiving facility, One for Transferring facility.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(can place patient identification label here)

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| PHYSICIAN SECTION  1. Reason for Transfer    2. Risk of Transfer (Choose one)   * This patient’s condition is at risk (active labor is stabilized only by delivery), however, patient will benefit from higher level of care not available at this facility. * This patient is not at risk such that with reasonable medical probability no deterioration of this patients’ condition (or that of the unborn child) is likely to result from transfer. * Patient or responsible person requests this transfer.   Potential Transfer risks can include:   * Death * MI/ Cardiac Decompensation * Respiratory/Pulmonary Decompensation * Bleeding * Delivery of High Risk Infant * Deterioration of Medical/Surgical/Psychological Condition   Primary diagnosis/condition of patient prior to transfer:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | NURSING SECTION  1. Consent to Transfer   * I understand the risks and benefits of my transfer. * I hereby consent to transfer with the recommended mode of transport. * I hereby consent to transfer but refuse the mode of transport. * I hereby refuse transfer and have been informed of the risks involved. * Patient involuntary transfer (72-hour hold). * Patient refuses to sign     Patient Signature or Responsible Person Relationship  Reason patient is unable to sign:  Witness: |
| 2. Vital Signs Before Departure    Date Time Pain Rating (0-10 Scale)    Temp Pulse Resp    BP O2 O2 Saturation \_\_\_\_\_\_\_\_\_ |
| 3. Acceptance of Transfer  Accepting Physician    Name Time of Acceptance  Physician to Physician Contact  Yes  No |
| 3. Receiving Facility Capability Acceptance      Name of Receiving Facility Date/Time of Acceptance  *All the following conditions must be met prior to transfer*   * The receiving facility has available space and qualified personnel for treatment of the patient. * The receiving facility has agreed to accept transfer and provide appropriate medical care. * The receiving facility will be provided with all appropriate medical records of the examination and treatment of patient. * The patient will be transported by qualified personnel and transport equipment, as required, including the use of necessary and medically appropriate life support measures. * Family notified of transfer   Nurse to Nurse Report:  Print Receiving Nurse Name Print Transferring Nurse Name  Signature of Transferring Nurse Date/Time  Patient was received at:  Date/Time  Patient is assigned to:  Room/Floor  Patient is under the care of:  Name of primary care provider |
| 4. Level / Method of Transport  Air Ambulance  ALS Ground Ambulance  BLS Ground Ambulance Law Enforcement (72 Hour Hold)  Other (i.e. OB Nurse / ICU Nurse / Resp Care)  Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time Notified:\_\_\_\_\_\_\_\_\_\_\_\_ Approximate time of departure:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5. Physician certification  Based on my examination of the patient and the information available to me at the time of transfer, I certify that the risks of transfer, including the risk of vehicular accident and transport hazards, are outweighed by the benefits reasonably anticipated from proper care of the patient (and/or her unborn child). I have explained the reason and risk of transfer to the patient, family, and or patient representative.  Print Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Signature:  Date/Time:  SPECIAL NOTE TO RECEIVING FACILITY: Please complete the box to the right and fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_within four (4) hours of receipt/acceptance of the patient. |
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