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.

Patient Name: _____

Patient Date of Birth: _____

(can place patient identification label here)

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

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:

_____

_____

3. Acceptance of Transfer

Accepting Physician

_____

Name Time of Acceptance

Physician to Physician Contact ☐ Yes ☐ No

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.

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 _____ O_2 _____ O2 Saturation _____

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