AUTHORIZATION FOR TRANSFER – PAGE 1

Patient's Name (please print)	Date	Medical Records Number

PHYSICIAN

I. Reason for transfer: _____

II. Patient Condition (Check one of the following):

❒ ***Patient does not have an emergent medical condition.***
This patient has been examined and does not have an emergent medical condition (includes severe pain, active labor, psychiatric disturbances or symptoms of substance abuse), such that the absence of immediate medical attention could result in serious jeopardy to the health of the individual or serious dysfunction of any bodily part or organ.
Note: If this section applies, only page 1 of this form must be completed.

❒ ***Patient has been stabilized***
This patient has been examined, does have an emergent medical condition which has been stabilized such that, within reasonable medical probability, no material deterioration of this patient's condition is likely to result from or occur during transfer.
Medical Risks: _____
Medical Benefits: _____
Note: If this section applies, only page 1 of this form must be completed.

❒ ***Patient has not been stabilized***
This patient has been examined and does have an emergent medical condition which has not been stabilized.
Note: If this section applies, the entire 2 page form (excluding section six) must also be completed.

III. Receiving Facility (Complete all of the following):

❒ The receiving physician has agreed to accept this patient at the receiving facility and provide appropriate medical treatment.
Name of receiving physician: _____ Time: _____

NURSING

❒ The receiving facility has available space, has qualified personnel for the treatment of this patient, has agreed to accept the transfer and shall provide appropriate medical treatment.
Name of receiving facility: _____
Person/title accepting for facility: _____ Time: _____
Nursing report given to: _____ Time: _____

IV. Mode/Support/Treatment During Transfer (Complete Applicable Items):

Mode of transportation for transfer: ❒ BLS Ambulance ❒ ALS Ambulance ❒ Helicopter ❒ Private Car
❒ Transport Team ❒ Other: _____
Time: _____ T _____ P _____ R _____ B/P _____ 02 Sat _____% ❒ RA ❒ 02 Initials _____
Support /Treatment during transfer: ❒ Cardiac Monitor ❒ Oxygen - amt: _____ ❒ Restraints - Type: _____
❒ IV Type: _____ ❒ Rate: _____ ❒ Pulse Oximeter ❒ IV Pump
❒ Patient ID applied _____ (location) ❒ Other: _____

V. Accompanying Documentation (Check Appropriate Items):

The receiving facility was provided a copy of all appropriate medical records pertaining to this patient's condition:

❒ Emergency Department Record	❒ Nurses Notes	❒ Lab Tests
❒ Medication Record	❒ History & Physical	❒ EKG
❒ X-Ray/Diagnostic Films	❒ Copy of Transfer Form	❒ Other: _____

VI. Family Considerations:

❒ Patient Belongings Given to Family ❒ Patient Belongings Transferred with Patient;
❒ Name of Accepting Physician and Accepting Facility Info Given to Family _____
❒ Family Given Directions to Accepting Facility

VII. Requests/Consents for Non-Emergent or Stable Patient (Complete Appropriate Items):

This patient who does not have an emergent medical condition or whose medical condition has been stabilized acknowledges and understands the risks and benefits described in section I: ❒ requests ❒ consents to the transfer.
Signature of: ❒ Patient ❒ Responsible person: _____ Relationship: _____
Witness _____ Second Witness: (If oral/telephone/patient mark) _____
❒ Parent/Responsible person transporting the patient by private car has been instructed to go directly to accepting facility.

SIGNATURES

Physician _____ Nursing _____

WHITE – CHART YELLOW – RECEIVING FACILITY PINK – TRANSPORTATION

AUTHORIZATION FOR TRANSFER

PATIENT LABEL

AUTHORIZATION FOR TRANSFER – PAGE 2

COMPLETE THIS PAGE WHEN PATIENT IS NOT STABILIZED

Patient's Name (please print)	Date	Medical Records Number

PHYSICIAN

VIII. Medical Risks and Benefits - (Physician to complete appropriate items):

Medical Risks of Transfer: _____

_____

_____

Medical Benefits of Transfer: _____

_____

_____

Patient Refuses ❒ Examination ❒ Treatment ❒ Transfer with medical risks being:_____

_____

_____

_____

IX. Certification of Need for Transfer

I have examined this patient and based upon the reasonable risks and benefits described above and upon the information available to me, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

Certifying Physician: _____Signature: _____

NURSING

X. Consent/Refusal (Complete all of the following):

This ❒ patient or ❒ responsible person acting on behalf of the patient having been informed of the risks/benefits of transfer transfer and/or the risks of refusal to examination, treatment and/or transfer as documented in Section VI above:
❒ Requests and/or ❒ Consents to transfer ❒ Refuses to consent to transfer ❒ Refuses examination ❒ Refuses treatment
Signature of:
❒ Patient ❒ Responsible person: _____ Relationship: _____
Witness _____ Second Witness: (If oral/telephone/patient mark) _____
❒ Parent ❒ Responsible person instructed to go directly to accepting facility
❒ If applicable, reason for request to transfer or refusal to transfer _____

XI. Complete as appropriate

Name of any on-call physician who refused to see the patient or failed to appear within a reasonable time:

Name _____

Address: _____

Contacted by: _____

Time of contact: _____Time of response:_____

XII. Signatures

If different than certifying physician, name and title of person(s) completing any section of this form.

_____

_____

_____

_____

WHITE – CHART YELLOW – RECEIVING FACILITY PINK – TRANSPORTATION

PATIENT LABEL

AUTHORIZATION FOR TRANSFER