IMPORTANT LEGAL NOTICE
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 does participate in Medicare and Medicaid.

1 Patient Condition
A. [ ] There is no reasonable likelihood of deterioration from or during transport.
B. [ ] The patient may be at risk for deterioration from or during transport.
C. [ ] Patient is Pregnant with contractions

Based upon my examination of the patient and the information available to me at the time of transfer, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

Signature: ___________________________ Time: ___________________________

Counter-signed by:

2 Reason For Transfer
A. [ ] For equipment or services not available at this facility: (list)

B. [ ] Patient-initiated request for transfer. Services are available here and offered to patient, who wishes of their own volition and request to be transferred.

3 Hospital Acceptance
A. Name of destination hospital: ___________________________

B. Accepted by: ___________________________ Name: ___________________________ Time: ___________________________

( ) INITIALS OF PERSON OBTAINING ACCEPTANCE

C. Accepting MD: ___________________________ Name: ___________________________ Time: ___________________________

( ) INITIALS OF PERSON OBTAINING ACCEPTANCE

4 Risks of Transfer

[x] All transfers have inherent risks of delays or accidents in transit, pain or discomfort upon movement, and limited medical capacity of transport units that may limit available care in the event of a crisis.

5 Benefits of Transfer

6 MODE OF TRANSPORT

[ ] ALS Ambulance
[ ] BLS Ambulance
[ ] Helicopter
[ ] Fixed Wing Aircraft
[ ] Additional Personnel:
  [ ] RN
  [ ] Respiratory Therapist
  [ ] MD

Service contacted: ___________________________ Time: ___________________________ ETA: ___________________________

7 Patient Consent to Transfer

I understand the risks and benefits of my [patient's] transfer.
[ ] I hereby CONSENT to transfer

[ ] I hereby REFUSE transfer

PATIENT SIGNATURE OR REPRODUCT OF PATIENT: ___________________________ Time: ___________________________

WITNESS: ___________________________ WITNESS: ___________________________

Discharge Vitals

<table>
<thead>
<tr>
<th>Discharge Vitals</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>B/P</td>
<td>Pulse</td>
</tr>
<tr>
<td>Resp</td>
<td>Temp</td>
</tr>
</tbody>
</table>