

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

Discharge Vitals	Time:
B/P	Pulse
Resp	Temp

4 Risks of Transfer

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: _____
 By _____ 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 ON BEHALF OF PATIENT _____ TIME _____

WITNESS _____ WITNESS _____