Hospital Logo

MRMC INPATIENT TRANSFER FORM

(This form applies to inpatients *only)*

PHYSICIAN ASSESSMENT AND CERTIFICATION TO TRANSFER

(Retain Original Copy in Medical Record)

Patient Name: _____ Age: _____ yrs Medical Record #: _____ Date: ____/____/____

Family/Patient Representative: _____ Contact Information/Number: _____

Date Family/Patient Representative Notified: _____/_____/_____ Time: _____:_____ am/pm Staff: _____

Patient Diagnosis: _____

Patient Condition	
□ The patient is stable so that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the transfer.	
□ The patient is unstable, but the expected medical benefits of transfer outweigh potential risks associated with the transfer.	
Transfer Notification to Patient, Family/Patient Representative	
□ I have been informed and educated of the plan to transfer my care and treatment to the designated location listed below. I have been given the opportunity to ask questions and receive answers to my questions regarding the transfer. I have been educated and informed on the reason, risks, and benefits of my transfer. _____ (*Patient's Initials*) □ I have been informed and educated of the plan to transfer the care and treatment of the patient to the designated location listed below. I have been given the opportunity to ask questions and receive answers to my questions regarding the transfer. I have been educated and informed on the reason, risks, and benefits of the patient transfer. _____ (*Family/Patient Representative Initials*) Name of Family/Patient Representative:_____ Relationship to Patient:_____ ***(If patient/family/patient representative is unable to initial document, verify response with two (2) witnesses)*** Name of Patient/Family/Patient Representative: _____ Relationship to Patient: _____ Witness Signature: (1)_____ (2)_____ Date: _____/_____/_____	
Reason for Transfer	
□ The transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met in the facility and is medically indicated	
□ The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility	
□ The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient;	
□ The health of individuals in the facility would otherwise be endangered;	
□ The patient has failed, after reasonable and appropriate notice, to pay for or to have paid under Medicare or Medicaid a stay at the facility. *(Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay).*	
□ The facility ceases to operate.	
□ Patient/Resident Appeal, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	
□ Patient/Family Request	
□ Physician Recommendation	
□ On call or Qualified Medical Professional (QMP) refused or failed to respond in a timely manner: Name of QMP:	
Benefits of Transfer	**Risks of Transfer**
□ Specific benefit of transfer:	□ Primary risk of transfer:
□ Specialized equipment, services, specialist & technology at receiving facility	□ Deterioration related to transport (e.g., accident, time delay)
□ Continuity of care:	□ Deterioration in condition □ Death □ Complications □ Permanent Disability
□ Benefits of transfer explained to: □ patient □ family □ patient representative	□ Risks of transfer explained to: □ patient □ family □ patient representative
Mode of Transport/Support/Treatment During Transport	
□ Ground EMS □ Air EMS □ Private Vehicle □ Police/Law Enforcement Agency:	
□ BLS □ ACLS □ IVF/IV Pump □ Medications: _____ □ Other:	
Ground Transport: (1) Is the treatment for which the patient is being transferred available at the hospital of origin? □ YES □ NO **(2)** If treatment is not available, what is the specific service(s) for which the patient is being transported?: _____. **(3)** Can the patient sit up in a chair? □ YES □ NO **(4)** If patient can sit in chair, amount of time patient can tolerate sitting: _____. **(5)** If patient confined to bed, what movement limitations prevent the patient from getting out of bed (e.g., paralysis, balance, etc.)?_____. **(6)** What illness created the limitations in #3? _____. **(7)** Does the patient require O2 for this transport? □ YES □ NO	

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(8) For what condition is it required? _____.
Other Conditions: (1) Other conditions affected by travel in such a way that without ambulance transportation, harm would come to the patient: _____
(2) What harm might be expected? _____.

Air Transport: □ Needs higher level of care □ Weather conditions prohibit ground transport □ Patient's condition is too critical to allow longer transport time by ground □ Patient's condition is too unstable for a ground unit from this institution to transport the patient and requires the special skills and abilities of the transport team □ Physician specialist is required for the patient's care and is not available at this institution (circle care option): cardiologist, vascular surgeon, neurosurgery, neurologist, trauma surgeon, cardiothoracic surgeon, burn specialist, gastroenterologist, pulmonologist, other: _____
□ Intensive care required for this patient which is not available at this institution □ Patient may require an emergent procedure that is not available at this institution. Anticipated procedure (circle care option): CABG, emergent catherization, emergent CT scan to rule out operable lesion, emergent surgery by a specialist not available at this institution (circle care option): balloon angioplasty, emergent dialysis, other: _____

ACCEPTANCE FOR ONGOING CARE

At _____ am/pm, _____ spoke with a representative of _____ (indicate receiving facility) who indicated that the hospital/facility would accept the transfer of the above referenced patient.

At _____ am/pm, I talked with Dr. _____ at _____ who was advised of this patient's condition and who agreed to accept the transfer of this patient for provision of appropriate medical treatment.

Nursing report given to _____ by _____at _____ am/pm on _____/_____/_____.

Accompanying Documentation	**Copies Sent Via**
□ Lab/X-ray/EKG □ H&P □ Progress Notes (last 5 days) □ Court Order □ Advance Directive □ Face Sheet □ Transfer Order □ Medication Record	□ Patient □ Fax □ Transport Personnel

Patient Assessment Time: _____:_____ Date: _____/_____/_____	
Vital Signs	Temp: Pulse: RR: O2 Sat: %
Neuro	
Cardio/Pulmonary	
GI/Urinary	
MS	
Integumentary	
MS/Mobility	
Last BM	
Lines/Tubes	
Fall/Safety Risk	
Special Precautions/Instructions	

PATIENT CONSENT

□ I hereby consent to transfer after having been informed of the risks and benefits of the transfer. In addition, I hereby authorize and request any and or all health information relevant to my medical condition in the possession of the facility as it exists at this time may be released and delivered to the above-named receiving facility.

□ I hereby request transfer to _____ after having considered the risks and benefits of the transfer and the physician's recommendation.

_____ _____Date: _____/_____/_____

(Patient/Patient Representative) *(Relationship to Patient)*

_____ Date: _____/_____/_____

(Witness)

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PATIENT REFUSAL

I hereby □ refuse to be transferred □ refuse to let the patient be transferred □ refuse ambulance transport □ refuse air transport. The hospital's responsibilities, risks and benefits of appropriate transfer and the physician's recommendations have been considered and this refusal of transfer or ambulance or air transport is made by me, independently and voluntarily.

_____ _____ Date: _____/_____/_____

(Patient/Patient Representative) *(Relationship to Patient)*

_____ Date: _____/_____/_____

(Witness)

PATIENT TRANSFER INFORMATION

Time of Transfer: _____:_____ am/pm Date of Transfer: _____/_____/_____ Transfer Disposition: _____

Transferring Nurse Signature: _____ Date: _____/_____/_____

PROVIDER CERTIFICATION

I have examined the patient and explained the risks and benefits of being transferred and/or refusing transfer of the patient as indicated by the patient's decision to consent or refuse.

Based on these reasonable risks and benefits to the patient, and based upon the information available at the time of the patient's examination, I certify:

□ The medical benefits reasonably to be expected from the provision of appropriate treatment at another medical facility outweigh the risks, if any, to the individual's medical condition.

□ The transfer is at the request of the patient/family after explanation that the potential risks outweigh the benefits, if any, to the individual's medical condition.

Physician Signature: _____ Date: _____/_____/_____

Contact Information for Care Provider

Name: _____ Contact Number: _____