EMTALA

REFUSAL OF TRANSFER TO ANOTHER MEDICAL FACILITY

(SEND COPY WITH PATIENT)

I hereby acknowledge that a physician or qualified medical person has informed me of the nature of my medical condition and about the risks and complications that might arise if I am not transferred to another facility for further medical examination and treatment. He or she has also explained to me the risks and expected benefits of alternatives being transferred to another medical facility as well as probable consequences of refusing the transfer

The expected benefits of the recommended examination and treatment:

_____

_____

The risks of not receiving the recommended examination or treatment:

_____

_____

I understand that if I am not transferred to another medical facility, my health and life, and if pregnant and having contractions, the health and life of my unborn child, may be at risk. I also understand that [insert Hospital's name] is obligated by federal law to provide me with further examination to the extent necessary to determine whether I have an emergency medical condition and with treatment necessary to stabilize any emergency medical condition within the capability of the hospital regardless of whether I am able to pay for that examination or treatment or if I do not have insurance.

Notwithstanding the recommendation of the physician or qualified medical person, I hereby request that I not be transferred to another medical facility because:

_____

_____

I hereby release [insert Hospital's name] its personnel, my attending physician or QMP, and any other persons participating in my care from any responsibility whatsoever from unfavorable or untoward results which I understand may occur as a result of my refusal to permit this transfer.

_____ _____

Patient/Legally Responsible Person Date

_____ _____

Relationship if other than the patient

_____ _____

Print Witness Name

I have explained to the patient (or legally responsible person) the probable consequences of not receiving further medical examination and treatment for the Emergency Medical Condition.

_____	_____	_____
Physician/Qualified Medical Person Signature	Date	Time
_____	_____	_____
Physician Counter Signature, if applicable	Date	Time
_____	_____	_____
Primary Nurse Signature	Date	Time
_____	_____	_____
Interpreter Signature/ID#	Date	Time

NOTE: If the patient refuses to sign such a statement, he/she cannot be forced to do so nor may his/her release be withheld until he/she signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement written on the form ***"Risks explained but signature refused."***