COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

EMTALA

TRANSFER CERTIFICATE FOR STABLE PATIENTS

(SEND COPY WITH PATIENT)

FOR UNSTABLE PATIENTS, COMPLETE
"TRANSFER CERTIFICATE FOR UNSTABLE PATIENTS"

Transfer Date:_____ Time: _____

SECTION I Physician Certification

□**STABLE FOR TRANSFER** – Based on the examination of the medical information available to me at this time, I have concluded that, as of the time of the transfer and/or discharge, the patient's emergency medical condition, if any, has been stabilized such that no material deterioration of the patient's condition is likely, within reasonable medical probability, to the result from or occur during the transfer of the patient and/or after discharge.

Reason for Transfer □ _____

□ Patient requests transfer □ Other _____

Medical Benefits of Transfer (Check all that apply)

□Necessary, staff resources, or capabilities are not available at this facility, OR

□Specialized care is not available at this facility; OR

□Other _____

All transfers have inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain, turbulence, and the limitations of equipment and personnel present in the vehicles, all of which endanger the health, medical safety, and survival of the patient(s).

I certify that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual and, in the case of labor, to the unborn child, from accepting the transfer.

Physician/Qualified Medical Person Signature:_____ Date: _____ Time: _____

Physician Countersignature, if applicable: _____ Date: _____ Time: _____

SECTION II

□ Receiving physician has agreed to accept patient transfer

Name: _____ Contact Time: _____

□ Receiving facility has agreed to accept patient transfer, provide appropriate personnel and treatment, and has available space.

Facility: _____ Contact Time: _____

Person accepting transfer _____ Title: _____

□ Receiving facility will be provided with appropriate medical/treatment information.

□ EKG □ LAB □ X-RAY/REPORT □ ED RECORD □ H&P □ OTHER (specify): _____

SECTION III Transportation

Patient will be transferred by qualified personnel and transportation equipment, as required, including the use IF necessary and medically appropriate life support measures during the transfer.

Mode of transportation/provider (check one)

□ Ambulance Service _____

□Air transport service _____

□Private vehicle _____

□Law Enforcement _____

□Other _____

Personnel to accompany patient in transfer (check all applicable)

EMS: □Basic □Intermediate □Paramedic

□Nurse

□Respiratory Therapist

□Physician

□Other _____

Primary Nurse Signature: _____

SECTION IV Patient Acknowledgement/Request – Check ONE of the following if transferred:

□**TRANSFER ACKNOWLEDGEMENT –** I understand that I have/the patient has the right to receive medical screening, examination and evaluation by a physician, or other appropriate personnel, without regard to my/the patient's ability to pay, prior to any transfer from this hospital. I have/the patient has the right to be informed of the reason(s) for any transfer. I have/the patient has, been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I acknowledge that I have/the patient has received medical screening, examination, and evaluation by a physician, or other appropriate personnel, and that I have been informed of the reason(s) for my/the patient's transfer. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

□**PATIENT REQUEST FOR TRANSFER –** I have/the patient has, requested a transfer and acknowledge that I have been informed of the risks and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I also acknowledge the obligation of this hospital to provide such further examination and treatment, within its available staff and facilities, as may be required to stabilize my/the patient's care. I have/the patient has released the hospital and its agents and employees from all responsibility for any ill effect(s) which may result from the transfer or the delay involved in the transfer.

Patient/Legally Responsible Person _____

Relationship if other than patient_____ Date: _____ Time_____

Witness_____ Title_____ Date:_____Time_____

Physician/Qualified Medical Person Signature_____ Date:_____Time_____

Print Physician/Qualified Medical Person Signature _____

Physician Countersignature, if applicable_____ Date _____ Time_____

Interpreter Signature/ID#_____ Date_____Time_____