

TRANSFER CONSENT

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.

| PHYSICIAN SECTION |
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| 1. Reason for Transfer <input type="checkbox"/> Need for higher level of care not available at RMH <input type="checkbox"/> Need for diagnostic equipment not available at RMH <input type="checkbox"/> Patient/responsible person's request. <input type="checkbox"/> Appropriate service/resource not at RMH List: _____ _____ |
| 2. <input type="checkbox"/> Alternatives to transfer discussed with patient: List if any _____ _____ |
| 3. ACCEPTING PHYSICIAN: _____ Name _____ Time of Acceptance _____ |
| 4. MEDICAL CONDITION (list diagnosis) _____ |
| 5. PATIENT CONDITION A. <input type="checkbox"/> There is no reasonable likelihood of deterioration from or during transport. B. <input type="checkbox"/> The patient may be at risk for deterioration from or during transport, but benefits outweigh the risks. C. <input type="checkbox"/> Patient is pregnant - contractions |
| 6. LEVEL OF TRANSFER (Must check a level) (If patient / family refuses level of transfer assigned, see # 10) Qualified personnel will transfer the patient. <input type="checkbox"/> BLS Ambulance <input type="checkbox"/> Critical Care Ground <input type="checkbox"/> ALS Ambulance <input type="checkbox"/> Critical Care Flight |
| 7. RISKS OF TRANSFER <input type="checkbox"/> Cardiac decompensation <input type="checkbox"/> Pulmonary decompensation <input type="checkbox"/> Bleeding <input type="checkbox"/> Deterioration of medical condition: _____ _____ <input checked="" type="checkbox"/> Vehicular accident/transport hazards <input type="checkbox"/> Death |
| 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. I have explained this to the patient / patient's legally responsible representative _____ Physician Signature _____ Date _____ |

| HOSPITAL SECTION | | | | | | |
|--|--------------------------|------------|----------|-------------|-------------------------|--|
| 8. DATE OF TRANSFER _____ / _____ / _____ | | | | | | |
| 9. HOSPITAL ACCEPTANCE OF TRANSFER A. Name of destination hospital: _____ _____ B. Accepted by: _____ Name of person at Destination Hospital _____ Time _____ C. Acceptance obtained by _____ _____ RMH Staff Person | | | | | | |
| 10. PATIENT CONSENT TO TRANSFER I understand the risks and benefits of my transfer. <input type="checkbox"/> I hereby CONSENT to transfer with the recommended mode of transport. <input type="checkbox"/> I hereby consent to transfer but refuse the recommended mode of transport. <input type="checkbox"/> Patient involuntary transfer (72 hour hold) <input type="checkbox"/> I hereby REFUSE transfer. _____ Patient signature or patient's legally responsible representative _____ Reason patient unable to sign _____ Witness _____ | | | | | | |
| 11. TRANSPORTATION Service contacted: _____ By _____ Time _____ RMH Staff Person Expected Arrival at Rice Memorial Hospital _____ | | | | | | |
| 12. VITAL SIGNS REPORTED AT HAND OFF <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Pain Scale Rating: _____</td> <td style="width: 30%;">TEMP _____</td> </tr> <tr> <td>BP _____</td> <td>PULSE _____</td> </tr> <tr> <td>RESP _____ O2 Sat _____</td> <td></td> </tr> </table> Report given to _____ By _____ Receiving Hospital RN _____ RMH RN _____ | Pain Scale Rating: _____ | TEMP _____ | BP _____ | PULSE _____ | RESP _____ O2 Sat _____ | |
| Pain Scale Rating: _____ | TEMP _____ | | | | | |
| BP _____ | PULSE _____ | | | | | |
| RESP _____ O2 Sat _____ | | | | | | |
| 13. COPIES OF MEDICAL INFORMATION <input type="checkbox"/> Medical Record <input type="checkbox"/> EKG <input type="checkbox"/> X-ray / Lab <input type="checkbox"/> Medication/IV's <input type="checkbox"/> Other PKU <input type="checkbox"/> Done <input type="checkbox"/> Not Done | | | | | | |
| 14. INCOMING TEAM (WCC USE ONLY) Incoming Team _____ assumed care at _____ Name of Team _____ Time _____ Report given to _____ by _____ Receiving team RN _____ RMH RN _____ | | | | | | |

Patient ID _____