County
HOSPITAL

PROCEDURE: DOCUMENTATION OF TRANSFER

1. Date: ______________________ Name: ______________________ Hosp. #: ______________

2. Physician:
   A. Decision to transfer due to diagnosis ☐
   B. Decision to transfer due to patient request. ☐

3. Name of Receiving Facility Accepting Patient: ______________________

4. Name of Receiving Physician Accepting Patient: ______________________

5. Transfer by:
   A. Private car ☐
   B. Non-emergency ambulance with EMT ☐
   C. Emergency transfer with paramedic or nurse ☐
   D. Helicopter service: ______________ ☐

   Name Of Service ______________________

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6. Stabilization of Patient: *Physician must circle A, B, or C below as applicable.*

   A. I certify that the patient suffered from an emergency medical condition but was stabilized at the time of transfer.
   The patient has been informed of the risks and benefits of transfer.
   The risks of transfer include: ______________________

   These potential benefits of transfer include: ______________________

   B. I certify that patient suffered from an emergency medical condition and was in an unstabilized condition and based upon the reasonable risks and benefits and upon the information available at the time, the benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's condition from effects of the transfer.
   The risks of transfer include: ______________________

   These potential benefits of transfer include: ______________________

   C. The patient or the patient's representative is requesting transfer in writing, said request is being made against medical advice and after being informed of the risks and benefits of transfer.
   The risks of transfer include: ______________________

   These potential benefits of transfer include: ______________________

7. Physician signature: Dr.: ______________________ Date: ______________

If physician is not physically present at the time of transfer, signature of qualified medical person after direct consultation with physician.

For physician by: ______________________

Subsequent countersignature by Dr.: ______________________

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8. Sent to receiving facility:
   Records related to emergency medical condition ☐

   Results of any tests: (circle) lab x-ray ABG EKG

   Informed Written Consent of Patient (copy): ☐

   Other: ______________________ ☐

9. Nursing information communicated to receiving nurse: ☐ YES
   Name of Receiving Nurse: ______________________