## Interhospital Transfer Sheet

**DATE:**

**PATIENT’S NAME:**

**TRANSFERRING PHYSICIAN:**

**REASON FOR TRANSFER:**

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**HMO REQUEST?**
- [ ] Yes
- [ ] No

**PRIVATE MD REQUEST?**
- [ ] Yes
- [ ] No

**CONTACT NAME:**

**PHONE:**

---

**RECEIVING INSTITUTION:**

**PHYSICIAN ACCEPTING PT. AT RECEIVING INSTITUTION:**

**PHONE:**

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**PATIENT STABILIZED?**
- [ ] Yes
- [ ] No

**IF "NO", PROVIDE REASON(S) WHY**

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**ATTENDING ER PHYSICIAN’S SIGNATURE:**

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**RN REPORT GIVEN TO RECEIVING INSTITUTION?**
- [ ] Yes
- [ ] No

**IF "NO", PROVIDE REASON(S) WHY**

---

**PERSON ACCEPTING REPORT AT RECEIVING INSTITUTION:**

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**DOCUMENTS TRANSFERRED**

<table>
<thead>
<tr>
<th>Document</th>
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<tbody>
<tr>
<td>Nurse’s Notes</td>
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<tr>
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<td>X-Ray</td>
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**ACCOMPANIED BY:**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>RN</td>
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<tr>
<td>MD</td>
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<td>EMT</td>
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<td>PARAMEDIC</td>
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**MODE OF TRANSFER:**

**MY MEDICAL CONDITION WAS EVALUATED & EXPLAINED TO ME BY DOCTOR:**

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**THE RISKS OF MY TRANSFER ARE:**

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**THE BENEFITS OF MY TRANSFER ARE:**

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**I understand these risks and benefits, and consent to be transferred:**

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**SIGNATURE OF PATIENT**

**WITNESS**

**DATE & TIME**

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**PART OF THE MEDICAL RECORD**