Your Hospital's Logo Here

Interhospital TRANSFER SHEET

PATIENT IDENTIFICATION

DATE:	PATIENT'S NAME:	TRANSFERRING PHYSICIAN:

REASON FOR TRANSFER:

HMO REQUEST? ☐ Yes ☐ No IF "YES", PROVIDE

CONTACT NAME:	PHONE:

PRIVATE MD REQUEST? ☐ Yes ☐ No IF "YES", PROVIDE

CONTACT NAME:	PHONE:

RECEIVING INSTITUTION:

PHYSICIAN ACCEPTING PT. AT RECEIVING INSTITUTION:	PHONE:

PATIENT STABILIZED? ☐ Yes ☐ No IF "NO", PROVIDE REASON(S) WHY

ATTENDING ER PHYSICIAN'S SIGNATURE:

RN REPORT GIVEN TO RECEIVING INSTITUTION? ☐ Yes ☐ No IF "NO", PROVIDE REASON(S) WHY

PERSON ACCEPTING REPORT AT RECEIVING INSTITUTION:

DOCUMENTS TRANSFERRED

Nurse's Notes	☐ Y ☐ N	EKG	☐ Y ☐ N	Lab	☐ Y ☐ N
Chart Copy	☐ Y ☐ N	X-Ray	☐ Y ☐ N	Transfer Sheet	☐ Y ☐ N

ACCOMPANIED BY:

RN ☐ MD ☐ EMT ☐ PARAMEDIC ☐

TRANSFER CONSENT:

MODE OF TRANSFER:	MY MEDICAL CONDITION WAS EVALUATED & EXPLAINED TO ME BY DOCTOR:

THE RISKS OF MY TRANSFER ARE:

THE BENEFITS OF MY TRANSFER ARE:

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

SIGNATURE OF PATIENT (or legally responsible party - relationship / name)	WITNESS	DATE & TIME

PART OF THE MEDICAL RECORD