Patient Name: ______________________________

Date of Birth: ______________________________

SS#: ______________________________

Roosevelt Medical Center
EMTALA Transfer Form

Emergency Medical Condition (EMC) Identified: *(Mark appropriate box(es), then go to Section II)*

I. MEDICAL CONDITION: Diagnosis______________________________

P R O V I D E R

_____**No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified.

_____**Patient Stable -** The patient has been examined and any medical condition stabilized such that; within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

_____**Patient Unstable -** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that result from providing this transfer.

II. REASON FOR TRANSFER: ________Medically Indicated ________Patient Requested

______On-call provider refused or failed to respond within a reasonable period of time.

Provider Name:__________________________Address:______________________________

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits::	**Medical Risks::**
______________________________	______________________________
__Obtain level of care/service NA at this facility.	__Deterioration of condition en route ________
Service ______________________________	__Worsening of condition or death if you stay here. *There is always*
__Benefits outweigh risks of transfer.	*risk of traffic delay/accident resulting in condition deterioration.*

IV. Mode/Support/Treatment During Transfer as Determined by Provider (Complete Applicable Items):

Mode of transportation for transfer:_____BLS ____ALS ____Airflight ____Ground ____Private Care ____Other______________

Agency______________________________Name/Title accompany hospital employee______________________________

Support/Treatment during transfer: ____Cardiac Monitor ____Oxygen- (Liters)____ ____Ventalation Support

____IV Fluid _______ Rate_____ ____Restraints - Type____________ Other____________ ____None

V. Receiving Facility and Individual: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility/Person accepting transfer:______________________________ Time______________________

Receiving MD:____

Transfering Provider Signature ______________________________Date/Time ______________________

Per Dr. ____________________by____________________RN/Qualified Medical Personnel Date/Time______________

N U R S I N G

IV. ACCOMPANYING DOCUMENTATION - sent via:____Patient/Responsible Party ____Fax ____EMS

____Copy of Pertinent Medical Record _____Lab/EKG/X-Ray ____Copy of Transfer Form ____Court Order

_____Comfort One/DNR ____Other____

Report given to(Person/Title)____

Time of Transfer_____________ Date_______________ Nurse Signature______________________________

Vital signs just prior to transfer: T______ Pulse_______ R_______ BP_______ Time_______

Personal property____

Medicaid Transfer Approval 1-800-292-7114 (MT/WY) Approval______________________ Denied___________

P A T I E N T

VII PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUESTED" TRANSFER:

_____I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the provider responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

____I hereby REQUEST TRANSFER to______________________. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the provider's recommendation. I make this request upon my own suggestion and not that of the hospital, provider, or anyone associated with the hospital.

The reason I request transfer is____

____

Signature of__Patient__Responsible Person__________________________Relationship______________________

Witness:______________________________________Witness:______________________________________

Orginal-Chart Pink-Billing Department Yellow-Destination Facility