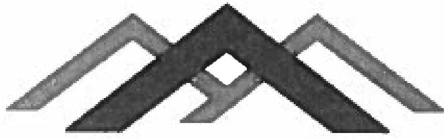

Beartooth Billings Clinic

Patient Sticker

Interfacility Transfer Authorization

Patient ____________________ DOB ____________
Diagnosis Primary ____________________

Sending Facility: Beartooth Billings Clinic ____________________ Phone Number: 406-446-0530 ____________
Receiving Facility: ____________________ Phone Number: ____________

Reason(s) for Transfer

☐ Requires service that Beartooth Billings Clinic ____________________ cannot provide.
☐ No appropriate bed available ☐ Patient / Family request ☐ Other Reason: ____________
Comments:

Acceptance

Receiving facility representative: ____________________ Date: ____________ Time: ____________
Receiving facility physician: ____________________ Date: ____________ Time: ____________

Transport

Agency: ____________________ Category: A.L.S. ☐ B.L.S. ☐
Mode: ☐ Ambulance ☐ Air (Fixed Wing) ☐ Air (Helicopter) ☐ Private Vehicle
Type: ☐ Emergency ☐ Non-Emergency
Specify level of care in transport: ☐ Physician ☐ RN ☐ Paramedic ☐ EMT ☐ Other: ____________
Time of Departure: ____________

Records Sent with Patient:

_____ Transfer Form _____ Face Sheet _____ Provider Record _____ Inpt. / Observation Record
_____ ER Record Electronic _____ ER Record Faxed _____ ER Record Paper Copy Sent
_____ Lab Results _____ 12 Lead EKG _____ Other ____________________
_____ X-Rays / CT Scans Digital _____ BC _____ St. V's Other Facility ____________________

Transfer Form Completed By: ____________________
Signature

Printed Name(s) of Preparer(s): ____________________

Certification by Physician for Transfer of Individual with Emergency Medical Condition

I have examined and evaluated the above-named patient, ____________________. Based on this examination and the information available to me at this time, I have concluded as of the time of transfer that within a reasonable medical probability, the transfer or delay caused by the transfer will not result in a material deterioration in or jeopardy to the medical condition or expected chances for recovery of the patient, (or, if pregnant, of the patient's unborn child). I have explained to the patient (or his or her legally responsible person) all of the expected medical benefits to be gained by the transfer, the medical risks posed by the transfer and why I believe that the benefits outweigh the risks of transferring this patient.

☐ Physician Certification: It is my medical judgement that the medical benefits associated with transfer outweigh the medical risks of transfer.

____________________ Signature of Provider
____________________ Print Name
Date: ____________ Time: ____________

____________________ Patient Signature or Responsible Party
____________________ Print Name
Date: ____________ Time: ____________