



**Big Horn Hospital Association
Memorial Hospital and
Nursing Home - Heritage Acres**

Health Care For All Life's Cycles

Patient Request for Transfer to Another Medical Facility

The purpose of this "Request For Transfer To Another Medical Facility" is to allow you/the patient to request in writing that you/the patient be transferred to _____ (receiving medical facility), even though you/the patient have an emergency medical condition that requires immediate treatment. By signing this form, you/the patient acknowledge the following:

1. You/the patient have been informed of the Hospital's obligations to you/the patient under Section 1867 of the Social Security Act (42 U.S.C. Section 1395dd), which include the following:
 - a) To provide you/the patient with an appropriate medical screening examination at your/the patient's request, and to determine if you/the patient are suffering from an emergency medical condition;
 - b) If an emergency medical condition exists, to transfer you/the patient to another medical facility only if (1) you/the patient request a transfer in writing after being informed of the Hospital's legal obligations to treat emergency medical conditions, and of the risks associated with transfer; or (2) a physician determines that the medical benefits of a transfer outweigh the risks, and that physician certifies in writing that those risks and benefits were thoroughly explained to you/the patient.
2. If you/the patient are pregnant, your/the patient's physician has certified in writing that the benefits outweigh the risks for both you/the patient and your/the patient's unborn child.
3. You/the patient acknowledge that you/the patient have been informed of the risks and consequence potentially involved in the transfer, the possible benefits of continuing treatment at the Hospital, and the alternatives (if any) to the transfer you/the patient request. You/the patient hereby release the attending physician, any other physician involved in your/the patient's care, the Hospital and its agents and employees, from all responsibility for any ill effects which may result from the transfer.
4. Despite the above information, you/the patient still request such a transfer.
5. If you/the patient have any questions you/the patient want to ask before you/the patient decide whether or not to request the transfer, we want and expect you/the patient to ask us.

By your/the patient's signature on this form, you/the patient acknowledge (1) that you/the patient have read and understood the information provided in this form; (2) that you/the patient have had a chance to ask questions; (3) that you/the patient have received all of the information you/the patient desire concerning transfer to another medical facility; (4) that you/the patient understand that you/the patient have a right to receive medical screening, examination, and evaluation by a physician or other appropriate personnel, without regard to your/the patient's ability to pay, prior to any transfer from the Hospital; (5) that you/the patient understand that you/the patient have a right to be informed of the reasons for any transfer; (6) that you/the patient request transfer to the medical facility named above; and (7) that you/the patient are being transferred for the following reasons: _____

Date: _____

Signature: _____
(Patient/Legal Representative)

Relationship to Patient: _____

Witness Signature: _____

Print Witness Name: _____

Patient Transfer Refusal

The risks and benefits for transfer have been explained to me and/or legal representative. I refuse transfer for further medical treatment against physician advice.

Date: _____

Signature: _____
(Patient/Legal Representative)

Relationship to Patient: _____

Witness Signature: _____

Print Witness Name: _____

Physician Certification of Transfer Refusal

I hereby certify that the risks of refusal to transfer for further medical treatment have been explained to the patient or legal representative.

Physician Signature: _____

Date: _____ Time: _____

Printed Name of Physician: _____

Non-Emergency Transfer: Emergency Transfer:

Signature of Qualified Medical Person: _____