BIG HORN COUNTY HOSPITAL
HARDIN, MONTANA

REQUEST FOR TRANSFER **CONSENT TO TRANSFER** **CERTIFICATION FOR TRANSFER**

PATIENT NAME: _____ **Chart Number:** _____ **Date:** _____ **Time:** _____ **AM/PM**

PATIENT CONDITION ON TRANSFER:.

☐ **Stable:** No material deterioration of the patient's medical condition, within reasonable medical probability, is likely to result from or occur during transfer.

☐ **Unstable:** Material deterioration of the patient's medical condition, including death, may result from or occur during transfer, but the benefits of transfer outweigh these risks.

Risks of Transfer:
☐ Medical condition could worsen during transport.
☐ Transportation risks.
☐ Other (NONE if not checked): _____

Benefits of Transfer:
☐ Availability of a higher specialized level of _____ care (*e.g., trauma, NICU*)
☐ Available capacity (e.g., qualified staff, beds, equipment) not currently available at this facility.
☐ Continuity of care.
☐ Patient Request
☐ Other (None if not checked): _____

PHYSICIAN OR QUALIFIED MEDICAL PERSON'S CERTIFICATION FOR TRANSFER:

I confirm the patient's condition and the benefit/risks of transfer as stated above. Based on the information available at the time, I have determined that the medical benefits reasonably expected from the provision of appropriate medical care at the receiving facility outweigh the increased risks to the patient and, in the case of labor, to the unborn child.
If the certifying physician is not physically present at the time of transfer, I have discussed the transfer with the physician named below, who certified the transfer and I concur with certification.

_____ _____

Certifying Physician Signature or Name (Print certifying physician's name if not present)

Signature of other physician or qualified medical person completing this form if applicable.

HOSPITAL ACCEPTANCE:

Acknowledgment & Name of Receiving Facility: _____

Staff Person Name **(Not MD)** _____ Time Contacted: _____ AM/PM
(Receiving facility staff person confirming available space and qualified personnel for treatment.)

Accepting Physician Name: _____ Time Contacted: _____ AM/PM
(Physician at the receiving facility accepting the patient in transfer.)

Contacted by: _____

MODE OF TRANSPORTATION:

Transported By:

☐ ALS Ambulance ☐ Air (fixed wing
☐ BLS Ambulance ☐ Air (helicopter)

Documentation Sent:

☐ Transfer Form ☐ ER Record
☐ Medical Records ☐ Laboratory Results
☐ X-Rays ☐ **Other** _____

PATIENT CONSENT FOR TRANSFER:

I have reviewed the information above and consent to be transferred to the receiving facility. I have been informed of the risks, benefits, and reasons for transfer. I have also been informed that the transferring hospital is required to stabilize my emergency medical condition unless I request to be discharged / transferred to another facility or unless the physician certifies that the medical benefits reasonably expected at the receiving facility outweigh the risks of transfer.

Patient **Witness** **Patient's Representative** **Relationship to Patient**

IF NO PHYSICIAN IS PRESENT:
Nurse's Name_____ Date_____ Time: _____
Nurse's Signature_____
On verbal orders of Dr._____
Received on (date) _____ at (time) _____
PHYSICIAN MUST COUNTERSIGN_____

Original Copy – Stays with chart
2nd Copy – Goes with transport staff
3rd Copy – Goes to designated office