



CENTRAL GENERAL HOSPITAL

1234 John Doe Blvd, Sometown, ST 55555 Phone:(111) 222-3333

Age: 26y Race: Caucasian Room: _____
Name: Doe Jane DOB: 12/31/1981 Sex: F
Accnt.# _____ MR # _____

EMTALA / COBRA / MEMORANDUM OF TRANSFER

(Patient) Doe Jane received a screening examination performed by (physician) _____
at (facility) Central General Hospital on (Date/Time) __/__/__ :__ and it was determined that the patient was in emergent
medical condition. Subsequent to the examination, a physician decision was made to transfer the patient to another health care facility.

PHYSICIAN CERTIFICATION

Stable Patient

Stabilization Established: The patient's emergency medical condition has been treated such that within reasonable medical probability no material deterioration of the condition is likely to arise from or during the transfer of the individual. If this patient is pregnant, delivery is not imminent and there is adequate time to affect a safe transfer before delivery without posing a threat to the health or safety to either the patient or the unborn child or the woman has delivered the child and placenta.

Unstable Patient: Medical treatment has been provided to minimize the risks to the patient or the health of the unborn child.

Reason for transfer of unstable patient:

Patient Request

Higher level of care required. Based on the patient's condition at this time, I certify that the reasonably expected medical benefits to the patient from appropriate treatment at the facility identified below outweigh the increased risks to the patient (and if the patient is pregnant, the risks to the unborn child) from being transferred.

On call MD or D.O. refused/failed to arrive for patient stabilization.

Analysis of Benefits vs. Risks of Transfer: Risks of all transfers include the possibility that the patient's condition may worsen en route, patient may be injured by a vehicular accident, equipment failure or increased pain or discomfort; and if the patient is in labor, she may progress to delivery while en route.

Other Risks: _____ **Benefits:** _____

Signature of transferring physician or QMP with MD Consult	Date	Name/Signature of consulting physician
Transferring Physician: _____ Receiving Facility: _____ <input type="checkbox"/> Provide appropriate medical treatment <input type="checkbox"/> space available	Time Transfer Initiated: <u>__/__/__ :__</u> <input type="checkbox"/> has agreed to accept patient.	COPIES sent with patient <input type="checkbox"/> Medical Records <input type="checkbox"/> Lab Reports <input type="checkbox"/> X-ray Reports <input type="checkbox"/> EKG <input type="checkbox"/> Other: _____ Patient Belongings: <input type="checkbox"/> NONE <input type="checkbox"/> Sent with family <input type="checkbox"/> Sent with patient <input type="checkbox"/> Other: _____ Family Notified: Time: <u>__/__/__ :__</u> Name: _____
Accepting Physician: _____ Report called to: _____ By: _____ Time: <u>__/__/__ :__</u> Nurse at accepting facility _____ Transferring RN _____	<input type="checkbox"/> qualified personnel for treatment (has accepted responsibility for pt.)	
Transferred by: _____ Transfer Time: <u>__/__/__ :__</u> Vital Signs within 15 minutes of transfer: BP _____ DBP _____ Pulse _____ Resp _____ Temp _____ FHTs _____ Pulse Ox _____ O2 _____	RN Signature: _____ Transfer Time: <u>__/__/__ :__</u>	

I HAVE BEEN INFORMED OF MY RIGHTS, RISKS & BENEFITS REGARDING: EXAMINATION, TREATMENT AND TRANSFER.
I give my permission for my medical records to be copied and sent to the receiving facility.
 I CONSENT TO BE TRANSFERRED **I REQUEST TO BE TRANSFERRED** **I REFUSE TO BE TRANSFERRED**
Signature of Patient / Legally Responsible Person: _____ Date: __/__/__ :__
Relation to Patient: _____ Witness: _____

1. Name of Hospital: _____ Address: _____ Phone Number: () _____	4. Receiving physician assuming care Date of Arrival: <u>__/__/__</u> Receiving Physician's signature: _____ Address: _____ Phone Number: () _____
2. Date of Arrival: <u>__/__/__</u> Time: _____	5. If response to transfer request was delayed beyond thirty (30) minutes document the reason(s) for the delay, including any time extensions agreed to by transferring hospital. Use additional sheet, if necessary. _____
3. Hospital Administration Signature: _____ Title: _____ Date: <u>__/__/__</u>	

DISTRIBUTION: Original to accompany patient to receiving hospital. Copy to be retained at transferring hospital.

Name: Doe Jane DOB: 12/31/1981 Sex: F