Consent for Transfer

1 Patient Condition

CHECK ALL THAT APPLY:

- ❑ There is NO reasonable likelihood of deterioration from or during transfer
- ❑ The patient may be at risk for deterioration from or during transport
- ❑ Patient is pregnant with contractions
- ❑ Other (Please specify) _____

_____

2 Reason for Transfer

CHECK ALL THAT APPLY:

- ❑ Medically indicated
- ❑ For equipment or services not available at this facility: (list)_____
- ❑ Patient initiated request for transfer. Services are available here and offered to the patient, who wished of their own volition and request to be transferred
- ❑ Staff not available
- ❑ Beds not available
- ❑ Other (Please specify)_____

_____

3 Medical Facility

A. Name of medical facility:

_____

B. Accepted by (name and time):

_____

C. Accepting Physician (name and time):

_____

D. Name of person obtaining acceptance:

_____

4 Risks of Transfer

CHECK ALL THAT APPLY:

- ❑ Deterioration of condition en route
- ❑ Risk of traffic delay or accident resulting in deterioration
- ❑ Other (Please specify) _____

_____

5 Benefits of Transfer

CHECK ALL THAT APPLY:

- ❑ Obtain higher level of care not available at FMH
- ❑ Benefits outweigh risk of transfer
- ❑ Other (Please specify) _____

_____

6 Alternatives to transfer, if any

PLEASE SPECIFY:

_____

_____

7 Patient Consent to Transfer

I understand the risks and benefits of my transfer:

- ❑ I hereby consent to transfer
- ❑ I hereby refuse transfer
- ❑ Incompetent to give consent

Patient signature or on behalf of the patient ***Date and Time***

- ❑ Unable to obtain signature

Witness ***Date and Time*** ***Witness*** ***Date and Time***

8 Provider Certification

Based upon my examination of the patient and the information available to me **at the time of transfer**, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

Signature ***Date and Time***

Patient Name & DOB

COPY AND PUT ORIGINAL IN MEDICAL RECORD