The Children's Hospital at BRONSON

Affix Patient Label

**1. General Information:**

Patient's Name: _____ Date of Birth:_____

Medical Diagnosis: _____

Current Facility: _____

Destination

Medical Care Facility: _____

Method of Transportation: ☐ Rotor Wing (helicopter) ☐ Ground Ambulance

**2. Explanation of Medical Condition and need for Transport:**

**I**, the above name Patient, or, if Patient is not competent to give this consent, his or her spouse, parent, family member or guardian, have been informed of the medical condition of the patient, and understand that this condition requires that the Patient be transferred to the Destination Medical Care Facility identified above. I understand that the Patient's physician has recommended that the Patient be transported by the methods of transportation indicated above from the Patient's Current Facility to the above name Destination Medical Facility, for further diagnosis, treatment and care.

**3. Risks of Transport:**

**I** understand that the transportation of the Patient involves certain risks, including:

a) the general risks associated with medical transport including possible medical equipment and/or vehicle failure, traffic hazards, adverse weather condition, interruption of medical treatment during transport; and

b) the risks associated with the Patient's condition, such as possible worsening of the Patient's condition during transport and/or inability to fully treat or diagnose a medical condition occurring during transport due to the unavailability of more sophisticated medical equipment and facilities not available in the transport vehicle; and

c) other inherent risks; if any, which may be anticipated by reason of the Patient's particular condition which have been reviewed with me by the ordering Physician.

All the questions which I have asked the Ordering Physician regarding this transfer have been answered to my satisfaction.

**4. Consent to Transport and Care:**

**I** believe the above risks are outweighed by the benefits offered to the Patient at the Destination Medical Care Facility. I therefore consent to transporting the Patient to the Destination Medical Care Facility and providing necessary medical care to the Patient during transport. I understand that employees, independent contractors shall be used to accomplish the transport.

**5. Authorization for Treatment:**

**I** consent to the performance of any emergency medical or surgical procedures or administration of blood or blood products which are deemed necessary by any medical personnel for the Patient during the transport and at the Destination Medical Care Facility.

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**6. Authorization for Release of Information:**

**I** authorize Bronson Hospitals and the Current Facility to release any medical information reasonably necessary or required to persons or entities involved or participating in the Patient's care or responsible for paying for the services rendered to the Patient. I understand that I am releasing Bronson Hospitals and the Current Hospital from any liability for furnishing such medical information and that neither these entities nor their employees shall be held responsible for subsequent passage of medical information that may occur by the third parties.

**7. Approval for Transfer:**

**I** have read and understand the content of this form and have been notified of the diagnosis and risks of transporting the Patient. I acknowledge and consent to the provision of care for the Patient as outlined by this consent. No guarantee or assurance has been made as to the results that may be obtained.

**8. Other:**

_____

**WITNESS(ES)**

_____ _____

Patient or person authorized to give consent on behalf of the patient

Date:_____ If not Patient,
Relationship to Patient:_____

Date:_____ Signature: _____