BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Authorization for Transfer of Patient/EMTALA

PHYSICIAN

I. MEDICAL CONDITION

DIAGNOSIS: _____

- ☐ No Emergency Medical Condition Identified: This patient has been examined and no E.M.C. identified.
- ☐ Patient Stable: The patient has been examined, an E.M.C. has been identified and stabilized such that within reasonable probability no deterioration of this patient's condition is likely to result from or occur during transfer.
- ☐ Patient Unstable: The patient has been examined, an E.M.C has been identified and the patient is not stable, but the transfer is medically indicated and is in the best interest of the patient.

* I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me. I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the risk of this transfer.

II. MODE / SUPPORT / TREATMENT DURING TRANSFER AS DETERMINED BY THE PHYSICIAN

Mode of transport: ☐ BLS ☐ ALS ☐ NICU ☐ Air
☐ Other: _____

Support / treatment during transport: ☐ Oxygen ☐ Pulse Oximetry ☐ Cardiac Monitor ☐ IV rate: _____

III. RISK AND BENEFIT OF TRANSFER *There is always risk of traffic delay / accident resulting condition deterioration

Specific Medical Risk: ☐ Death ☐ Delay in Treatment ☐ Deterioration of Medical Condition

Specific Medical Benefit: ☐ Availability of Specialized Services ☐ Facilities ☐ Diagnostic Equipment
☐ Personnel ☐ Other: _____

Risks / Benefits Explained to: _____
☐ Patient ☐ Patient's Family ☐ Other, relationship: _____

IV. REASON FOR TRANSFER

☐ Medically Indicated ☐ Patient Requested ☐ Other: _____ ☐ On-call physician failed to respond

V. RECEIVING INDIVIDUAL AND FACILITY

The receiving facility has the capability and capacity to treat this patient, adequate equipment and medical personnel, and has agreed to accept the transfer and provide appropriate medical treatment as determined by the person accepting transfer.

RECEIVING FACILITY	PERSON ACCEPTING TRANFER	TIME
PHYSICIAN SIGNATURE		DATE

NURSE

VI. ACCOMPANYING DOCUMENTATION ☐ Electronic Record

☐ Copy of Pertinent Medical Records ☐ Lab / EKG / X-ray ☐ Copy of Transfer Form ☐ Other: _____

Sent via: ☐ Electronic Record ☐ Transporter ☐ Patient/Responsible Party ☐ Fax: _____

PATIENT

VII. PATIENT CONSENT or REQUEST FOR TRANSFER

Medically Indicated: I give my **consent to be transferred** to another medical facility. The physician responsible for my care believes that the benefits of transfer outweigh the risks of transfer. The risks and benefits of this transfer have been explained to me and I have had the chance to ask questions about this transfer.

SIGNATURE

☐ RESPONSIBLE PERSON ☐ Patient

Relationship: _____

DATE | TIME

I Request Transfer to _____. I understand the hospital's responsibilities and my physician's recommendations. My physician has explained the risks and benefits of this transfer. The request is my decision and not the hospitals, the physician's, or anyone's associated with the hospital.

The reason I request the transfer is _____

SIGNATURE

☐ RESPONSIBLE PERSON ☐ Patient

Relationship: _____

DATE | TIME

Witness (RN, CM, MSW only)	SIGNATURE:	DATE:	TIME:

Complete Form: **Original Copy -** *Chart* | **One Copy -** *Receiving Facility* | **One Copy -** *Patient*