

**REASON FOR TRANSFER**

Medically Necessary    Patient Request

**MEDICALLY STABLE**

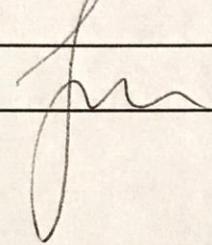
Yes    No

**RISKS/BENEFITS**

All transfers have the inherent risks of traffic delays, accidents during transport; inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle.

Benefits of Transfer: Higher level of care, psyc

Risks of Transfer: Decompensation of condition

Physician Signature:    Date: 3/9/18   Time: 12:00 pm

**PATIENT CONSENT**

I hereby consent to transfer to another medical facility. I have been informed of the risks and benefits upon which this transfer is being made. I have considered these risks and benefits and consent to transfer. I understand that privileged and/or confidential treatment information contained in my medical record will be forwarded to the receiving facility and I give my permission for such disclosure.

Signature of Patient  
or Responsible Person: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

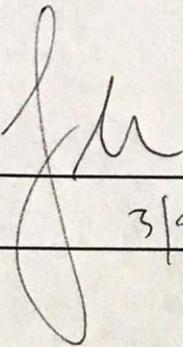
**PHYSICIAN**

Arrange Transfer to Dr: BOB

Mode of Transport:  ALS  BLS  Helicopter  Other \_\_\_\_\_

Orders for transport: (Equipment/Staff)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature:  MD  
Date: 3/9/18 Time: 1200 pm

**NURSING**

Receiving facility: \_\_\_\_\_

Name of Person Accepting for Hospital:

Copy of available records (lab/x-ray/EKG/Physician Notes/Nurses Notes/diagnostic

studies/results) sent:  Yes  No

Family notified:  Yes  No Belongings to family:  Yes  No

**Reassessment prior to transfer:**

TIME: \_\_\_\_\_ B/P: \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

Transporting Agency: \_\_\_\_\_

Time of Transfer: \_\_\_\_\_ Signature: \_\_\_\_\_ R.N.