McLaren Business Products

McLaren Print System Order

Order No: 58265
Order Date: 2020-11-09
User: Tim Zurek
Phone: 9892699521

Ship Location: Mclaren Thumb Region Emergency Room Attn: Tim
1100 S. Van Dyke Rd.
Bad Axe, MI 48731
Forms
Quantity: 100
Paragon Dept No: 060
Dept Name: Emergency Room
Company Number: 530

Order Total Price: 0.00

Item Number: 054.192
Item Description: EMTALA Authorization
Revision Date: 07/2018
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: SS; BLACK; BOND PAPER

Spec Info:

MCLAREN THUMB REGION EMTALA AUTHORIZATION

SECTION 1: Check one of the following:
☐ A. This individual does not suffer from an emergency medical condition.
☐ B. This individual has been stabilized such that, within reasonable medical probability no material deterioration of this individual's condition is likely to result from transfer.
☐ C. This individual's condition has not been stabilized.

SECTION 2: **IF section 1B or 1C has been checked,** one of the following **must** also be completed.
☐ A. This individual ☐ requests or ☐ consents to this transfer, and has been informed of the benefits and risks involved in transfer.
Individual's signature: _____
☐ B. The following legally responsible person acting on behalf of this individual ☐ requests or ☐ consents to this transfer, and has been informed of the benefits involved in transfer.
Signature of person requesting/consenting to transfer: _____
Relationship to the transferred individual: _____
☐ C. Based on the reasonable risks and benefits to this individual, and based upon the information available at the time of this individual's transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to this individual's (and/or their fetus') medical condition from affecting the transfer.

SECTION 3: BENEFITS: **Benefits and risks** of transfer (or refusal to undergo transfer):
☐ Availability of specialized services
☐ Facilities
☐ Diagnostic equipment
☐ Trained personnel
☐ Other: _____
RISKS:
☐ Death
☐ Deterioration of medical condition
☐ Delay in receiving appropriate treatment
☐ Other: _____

SECTION 4: Check items below as appropriate. **NOTE:** An individual may not be transferred unless **all** of the following requirements are met.
☐ A. The receiving facility has available space and qualified personnel for the treatment of this individual.
☐ B. The receiving facility has agreed to accept transfer and to provide appropriate medical treatment.
☐ C. Individual has been accepted at receiving facility by a responsible physician.
Name of receiving facility: _____
Name of physician accepting transfer: _____
☐ D. The receiving facility will be provided with all appropriate medical records for the examination and treatment of this individual.
☐ E. This individual will be transferred by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures.
Patient sent by: ☐ ALS ☐ BLS ☐ Air flighted
Patient accompanied by: ☐ EMT ☐ Paramedic ☐ RN ☐ Physician

SECTION 5: If the individual **refuses** transfer, check one of the following.
☐ A. This individual refuses transfer and has been informed of the risks involved in refusing transfer.
Individual's signature: _____
☐ B. The following legally responsible person acting on behalf of this individual refuses transfer and has been informed of the risks involved in refusing transfer.
Signature of person refusing transfer: _____
Relationship to the individual: _____

SECTION 6: If transfer of this individual is being made because the necessary on-call physician failed or refused to appear within a reasonable period of time, then that physician's name and address is listed as follows:
_____
_____

SECTION 7: Transferring physician's certification: I certify that I have answered the above questions based upon the information available to me at the time of this individual's transfer.
Name of physician certifying transfer: _____
Physician's Signature: _____ Date: _____

Vital Signs within 15 minutes of Transfer:
Time:_____ BP:_____ Pulse:_____ Resp. Rate:_____ Temp:_____
SPO2:_____

TRANSFERRED INDIVIDUAL'S NAME _____
Medical Record #:_____

Original to Medical Records Copy to Receiving Facility

054.192-07-18