

McLaren Print System Order

Order No: 58367
Order Date: 2020-11-12
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: 500
Paragon Dept No: 060
Dept Name: Emergency Room
Company Number: 530

Order Total Price: 117.00

Item Number: 054.192
Item Description: EMTALA Authorization
Revision Date: 07/2018
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: SS; BLACK; 2 PART

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, when reasonable medical probability is 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 foreseeable 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 in moving their legal medical condition from affecting the transfer.

SECTION 3: Benefits and Risks of transfer (or refusal to undergo transfer)
BENEFITS:
 Availability of specialized services **RISKS:** Death
 Facilities Deterioration of medical condition
 Diagnostic equipment Delay in receiving appropriate treatment
 Trained personnel 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: _____
 D. Name of physician accepting transfer: _____
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 resources.
Patient sent by: ALS BLS Air flight
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 to respond 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: _____ Date: _____
Physician's Signature: _____

Spec Info:
Your Sign within 15 minutes of Transfer:
Name _____ SP _____ Pulm _____ Resp. Path. _____ Trans. _____
SPID: _____

TRANSFERRED INDIVIDUAL'S NAME _____
Medical Record # _____
Original to Medical Records Copy to Receiving Facility