

**McLaren Health Care Corporation (MHCC)**

BAY CMI FLT LAP LAN MAC NMI (MAIN) NMI (CHEBOYGAN) OAK (MAIN) OAK (OXFORD) OAK (CLARKSTON)

**PATIENT TRANSFER CONSENT FORM**

**SECTION TO BE COMPLETED BY THE PHYSICIAN**

**I. Patient Condition**

Does the patient have an emergency medical condition?  Yes  No

Select One	<input type="checkbox"/> Stable	The patient has been stabilized such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from transfer. No other significant risks have been identified as associated with the patient's transfer at this time
	<input type="checkbox"/> Delivery Not Imminent	Within reasonable medical probability, no material deterioration of the mother or child is likely to result from transfer
	<input type="checkbox"/> Unstable	The patient's condition can not be stabilized prior to transfer
	<input type="checkbox"/> Delivery Imminent	The patient is a pregnant woman having contractions and there is inadequate time to safely transfer her to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or her unborn child

**TO BE COMPLETED WHEN TRANSFERRING AN UNSTABLE PATIENT**

The patient's emergency medical condition has not been stabilized. I have explained to the patient/legal representative the risks and benefits of transfer and medical treatment at the receiving facility

I certify that based on the reasonable risks and benefits to the patient, and based on information available at the time of the patient's examination, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks, if any, to the patient's medical condition from affecting transfer

I am unable to certify that the increased risks to the patient from affecting transfer are outweighed by the reasonably expected medical benefits of appropriate treatment at the receiving facility

Other Risks/Benefits of Transfer \_\_\_\_\_

**II. Reason for Transfer**

Select One	<input type="checkbox"/> Patient or their Legal Representative requests the transfer
	<input type="checkbox"/> Specialized services necessary to treat the patient are not available at MHC Facility <b>Specify:</b>
	<input type="checkbox"/> Patient's Personal Physician Request
	<input type="checkbox"/> Patient's Insurance Provider Requirement
	<input type="checkbox"/> OnCall Physician refused/failed to respond Name/Contact Information:
	<input type="checkbox"/> Other:

**III. Risks/Benefits of Transfer**

I have explained the significant risks and benefits of transfer to:  Patient  Legal Representative

Risks	<input type="checkbox"/> Death	<input type="checkbox"/> Delay in Treatment	<input type="checkbox"/> Worsening of Patient's Medical Condition(s)
	<input type="checkbox"/> Other:		

Benefits \_\_\_\_\_

**IV. Transfer Requirements – All Requirements Must Be Met**

Transferring Facility	MHC Facility	Department	Phone #
Transportation	<input type="checkbox"/> Other:		
	<input type="checkbox"/> ACLS ambulance	<input type="checkbox"/> BLS ambulance	<input type="checkbox"/> Helicopter <input type="checkbox"/> Fixed Wing Aircraft
Transporting Staff	<input type="checkbox"/> Paramedic	<input type="checkbox"/> EMT	<input type="checkbox"/> Other:
Medical Record	<input type="checkbox"/> Available medical record prepared for transport with patient		
Receiving Facility		Phone #	
Receiving Physician accepting transfer of the patient			
Receiving Facility has directed that the patient be taken upon arrival to		<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Room #

**V. Physician Certification**

I have explained the significant risks and benefits of transferring care to the patient. I have contacted the Receiving Facility obtaining verbal acceptance of the patient to be transferred. I have confirmed with the Receiving Physician that there are qualified personnel and resources available to treat the patient. I have confirmed that the patient will be transferred by qualified personnel, except in situations where the patient chooses to self-transport.

\_\_\_\_\_  
Physician Signature Printed Physician Name Date Time



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**PATIENT TRANSFER CONSENT FORM**

**SECTION TO BE COMPLETED BY THE PATIENT/LEGAL REPRESENTATIVE**

<input type="checkbox"/>	<b>MHC Facility Initiated Transfer – Patient Consent for Transfer</b>
The physician has explained to me why I need to be transferred to another facility. I understand the risks and benefits of the transfer. I have been advised of my rights regarding examination, treatment and transfer. I have been advised of the MHC Facility's emergency treatment obligations under the federal law. Based on the information available to me at this time, including that the expected medical benefits outweigh the risks, I choose to proceed with the transfer.	

<input type="checkbox"/>	<b>Patient's Insurance or Personal Physician Initiated Transfer – Patient Consent for Transfer</b>
My insurance provider or personal physician is requesting my transfer to another facility. The physician has explained to me the risks and benefits associated with the transfer. I have been advised of my rights regarding examination, treatment and transfer. I have been advised of the MHC Facility's emergency treatment obligations under the federal law. I choose to proceed with the transfer.	

<input type="checkbox"/>	<b>Patient Initiated Transfer – Patient Consent for Transfer</b>
I am requesting a transfer to another facility. I acknowledge that my medical condition has been evaluated and explained. The physician has explained to me the risks and benefits associated with the transfer. I have been advised of my rights regarding examination, treatment and transfer. I have been advised of the MHC Facility's emergency treatment obligations under the federal law. I am making this request of my own free will, without the influence of another individual. No one associated with the MHC Facility has influenced my request. I refuse to consent to further medical examination/treatment which has been offered to me. I choose to proceed with the transfer I have requested.	
Facility I Request Transfer To	_____

<input type="checkbox"/>	<b>Patient Refusal of Transfer</b>
I am refusing transfer to another facility. I have been advised of my rights regarding examination, treatment and transfer. I have been advised of the MHC Facility's emergency treatment obligations under the federal law. I am making this request of my own free will, without the influence of another individual. No one associated with the MHC Facility has influenced my request. I understand the risks and benefits of transfer explained to me by the physician. I understand that the physician believes the transfer to be in my best interest. I choose to continue receiving treatment at the MHC Facility.	

<input type="checkbox"/>	<b>Patient Refusal of Transportation Services</b>
I am refusing transfer to another facility via the method suggested by the physician. I am making this request of my own free will, without the influence of another individual. No one associated with the MHC Facility has influenced my request. I understand the risks of self-transportation explained to me by the physician. I choose to be responsible for arranging my transportation to the Facility to which I am being transferred.	

_____ Patient Signature	_____ Date	_____ Time
<input type="checkbox"/> Patient Unable/Unwilling to Sign	Reason _____	
_____ Legal Representative Signing on Behalf of Patient	_____ Legal Representative Printed Name	_____ Relationship to Patient
_____ Witness		



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PT.	
MR.#/RM.	
DR.	