McLaren Business Products

McLaren Print System Order

Order No: 74425
Order Date: 2023-01-04
User: Cheryl Hintze-Schneider
Phone: (586) 493-8198

Ship Location: McLaren Macomb, Administration 2nd Flr, MOB, Attn: Cheryl
1000 Harrington Boulevard
Mount Clemens , MI 48043
Forms
Quantity: 500
Paragon Dept No: 20600
Dept Name: Nursing Administration
Company Number: 260

Order Total Price: 238.00

Item Number: MHC-CC0125
Item Description: EMTALA Patient Transfer Consent Form
Revision Date: 6/2022
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: 5 Hole Top
Poster:
Misc Info: 2 pages - 2 part

Spec Info:

McLaren Health Care Corporation (MHCC)

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: Stable; Delivery Not Imminent; Unstable; Delivery Imminent

TO BE COMPLETED WHEN TRANSFERRING AN UNSTABLE PATIENT

II. Reason for Transfer

Select One: Patient or their Legal Representative requests the transfer; Specialized services necessary to treat the patient are not available at MHC Facility (Specify); Patient's Personal Physician Request; Patient's Insurance Provider Requirement; On-Call Physician refused/failed to respond (Name/Contact Information); Other

III. Risks/Benefits of Transfer

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

Risks: Death; Delay in Treatment; Worsening of Patient's Medical Condition(s); Other

IV. Transfer Requirements – All Requirements Must Be Met

Transferring Facility | MHC Facility | Department | Phone #

Transportation: Other; ALS ambulance; BLS ambulance; Helicopter; Fixed Wing Aircraft

Transporting Staff: Paramedic; EMT; Other

Medical Record: 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: Emergency Department; Room #

V. Physician Certification

Physician Signature | Printed Physician Name | Date | Time

MHC_CC0125
Appendix T 1

Page 1 of 2

8200