

**McLaren Print System Order**

Order No: 81100 Reprint Previous Order No: 80991  
Order Date: 2023-11-10  
User: Tina Losey  
Phone: 2316271302

Ship Location: McLaren Northern Michigan-Cheboygan ER  
748 S Main  
Cheboygan, MI 49721

**Forms**

Quantity: 100  
Paragon Dept No: 21600  
Dept Name: Cheboygan ER  
Company Number: 410

Order Total Price: 23.40

Item Number: MHCC-713-MNM  
Item Description: Patient Transfer Consent Form  
Revision Date: 10/2023  
Print: 1 sided black and white  
Paper: 2 Part (White, Yellow)  
Size: 8.5 x 11  
Fold:  
Finish: None  
Drill: None  
Misc Info: 2 Part, 8.5x11, Black

McLaren Health Care Corporation (MHCC)  
 MBR (BRAN)  MCR  MWR  FLT  LAF  MGL  MNC  NMM (BRAN)  NMM (CHEBOYGAN)  
 MTR  FLT (PONTIAC)  GM (BRAN)  GM (EASTLANS)  GM (CLAWSON)  MPP  MBR (WEST BRANCH)  MSL

**PATIENT TRANSFER CONSENT FORM**

**SECTION TO BE COMPLETED BY THE PHYSICIAN**

**A. Patient Condition**  
Does the patient have an emergency medical condition?  Yes  No

Select One:  
 Stable: The patient has been stabilized such that, within reasonable medical probability, no further deterioration of the patient's condition is likely to result from transfer. No other significant facts have been identified as associated with the patient's transfer within 3000.  
 Delivery Not Imminent: Within reasonable medical probability, no further deterioration of the mother or fetus is likely to result from transfer.  
 Unstable: The patient's condition can not be stabilized prior to transfer.  
 Delivery Imminent: The patient is a pregnant woman bearing contractions and there is inadequate time to safely transfer her to another hospital before delivery or another 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 receiving 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 reasonable expected medical benefits of appropriate treatment at the receiving facility.

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

**B. 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.  
 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: \_\_\_\_\_  
Benefits: \_\_\_\_\_

**IV. Transfer Requirements - All Requirements Must Be Met**  
Transferring Facility: MHC Facility Department: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Transportation:  Other  A&LS 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**  
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: \_\_\_\_\_