

McLaren Print System Order

Order No: 81849
 Order Date: 2023-12-26
 User: Jennifer Melcher
 Phone: 989-779-5637

Ship Location: McLaren Central Michigan / Attn: Vickie Barkley -ED
 1221 South Dr
 Mt Pleasant, MI 48858

Forms

Quantity: 500
 Paragon Dept No: 21600
 Dept Name: Supply Chain Management
 Company Number: 360

Order Total Price: 59.00

Item Number: 654-50
 Item Description: Authorization For Transfer
 Revision Date: 09/2020
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Poster:
 Misc Info: 8.5x11 Black 2-Part

McLAREN HEALTH CARE CORPORATION (MHCC)
 BAY BCM FLT LAF LVA MAC MB (BAY) MB (CHESBYGARE)
 MB (BAY) ORA (SPOFO) ORA (CLARKSTON)

PATIENT TRANSFER CONSENT FORM

ATTENTION LABEL

SECTION TO BE COMPLETED BY THE PHYSICIAN

I. Patient Condition

Does the patient have an emergency medical condition? Yes No

Select One: Stable The patient has been stabilized such that, after 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 within this time.

Delivery/Not Imminent After reasonable medical probability, no material deterioration of the mother or child is likely to result from transfer.

Imminent The patient's condition can not be stabilized prior to transfer.

Delivery Imminent The patient is a pregnant woman having contractions and there is inadequate time to safely transfer her to another facility before delivery or transfer may pose a threat to the health or safety of the mother or the 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 verify 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 verify 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: Patient or their Legal Representative requests the transfer

Specialized services necessary to treat the patient are not available at this Facility.

Specify:

Patient's Personal Physician Requested

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 or Treatment Worsening of Patient's Medical Condition(s)

Other:

IV. Transfer Requirements - All Requirements Must Be Met

Transferring Facility: SBC Facility Department Phone #

Transportation: Other: A/C/S 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: Emergency Department Phone #

Receiving Facility has directed that the patient be taken upon arrival to: Emergency Department Phone #

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: _____ Title: _____

Spec Info:

