

**McLaren Print System Order**

**Order No: 83586 Reprint Previous Order No: 6894**  
**Order Date: 2024-03-05**  
**User: Racquel Salas**  
**Phone: 517-975-7315**

**Ship Location: McLaren Greater Lansing- Attn: Racquel Salas**  
**2900 Collins Road**  
**Lansing, MI 48910**

**Forms**  
**Quantity: 500**  
**Paragon Dept No: 21600**  
**Dept Name: Emergency Department**  
**Company Number: 10**

**Order Total Price: 119.50**

**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**  
**Misc Info: 2 pages - 2 part**

McLaren Health Care Corporation (MHC)  
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**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 The patient has been stabilized such that, under 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 condition.  
 Delaying the treatment Under reasonable medical probability, no material deterioration of the patient or child is likely to result from transfer.  
 Unstable The patient's condition can 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 hospital before delivery or transfer may prove a threat to the health or safety of the patient 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 have explained the 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 effecting transfer.  
 I am unable to verify that the increased risks to the patient from effecting 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 MHC facility.  
 Specify: \_\_\_\_\_  
 Patient's Personal Physician Request  
 Patient's Insurance Provider Requirement  
 On-Call Physician Release/Referral is required  
 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  
 Other: \_\_\_\_\_  
 Benefits: \_\_\_\_\_

**IV. Transfer Requirements - All Requirements Must be Met**  
 Transferring Facility: MHC Facility Department: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Transportation:  Other  A/C's ambulance  M.C. 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 certified 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 confirmation 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: \_\_\_\_\_



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