

McLaren Print System Order

Order No: 85590 Reprint Previous Order No: 56985  
Order Date: 2024-05-18  
User: Brandee Blackstock  
Phone: 9892699521

Ship Location: McLaren Thumb Region  
1100 S. Van Dyke Rd  
Bad Axe, Michigan 48413

Forms

Quantity: 100  
Paragon Dept No: 530  
Dept Name: McLaren Thumb Med Surg Department  
Company Number: 530

Order Total Price: 23.40

Item Number: 054.192  
Item Description: EMTALA Authorization  
Revision Date: 07/2018  
Print: 1 sided black and white  
Paper: 2 Part (White, Yellow)  
Size: 8.5 x 11  
Fold:  
Finish: None  
Drill: None  
Misc Info: SS; BLACK; 2 PART

**McLAREN THUMB REGION EMTALA AUTHORIZATION**

**SECTION 1:** Check one of the following.

A. This individual does not suffer from an emergency medical condition.

B. This individual has been stabilized such that, when reasonable medical probability is material consideration of this individual's condition is likely to result from transfer.

C. This individual's condition has not been stabilized.

**SECTION 2:** If section 1B or 1C has been checked, one of the following must also be completed.

A. This individual  requests or  consents to this transfer, and has been informed of the benefits and risks involved in transfer.

Individual's signature: \_\_\_\_\_

B. The following legally responsible person acting on behalf of this individual  requests or  consents to this transfer, and has been informed of the benefits involved in transfer.

Signature of person requesting/consenting to transfer: \_\_\_\_\_  
Relationship to the transferred individual: \_\_\_\_\_

C. Based on the foreseeable risks and benefits to this individual, and based upon the information available at the time of this individual's transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to this individual in joining their local medical condition from affecting the transfer.

**SECTION 3: Benefits and risks of transfer (or refusal to undergo transfer)**

**BENEFITS:**

Availability of specialized services  Facilities  Diagnostic equipment  Trained personnel  Other \_\_\_\_\_

**RISKS:**  Death  Deterioration of medical condition  Delay in receiving appropriate treatment  Other \_\_\_\_\_

**SECTION 4:** Check items below as appropriate. **NOTE:** An individual may not be transferred unless all of the following requirements are met.

A. The receiving facility has available space and qualified personnel for the treatment of this individual.

B. The receiving facility has agreed to accept transfer and to provide appropriate medical treatment.

C. Individual has been accepted at receiving facility by a responsible physician.

Name of receiving facility: \_\_\_\_\_

D. Name of physician accepting transfer: \_\_\_\_\_

The receiving facility will be provided with all appropriate medical records for the examination and treatment of this individual.

E. This individual will be transferred by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support resources.

Patient sent by:  ALS  BLS  Air flight

Patient accompanied by:  EMT  Paramedic  RN  Physician

**SECTION 5:** If the individual refuses transfer, check one of the following.

A. This individual refuses transfer and has been informed of the risks involved in refusing transfer.

Individual's signature: \_\_\_\_\_

B. The following legally responsible person acting on behalf of this individual refuses transfer and has been informed of the risks involved in refusing transfer.

Signature of person refusing transfer: \_\_\_\_\_  
Relationship to the individual: \_\_\_\_\_

**SECTION 6:** If transfer of this individual is being made because the necessary on-call physician failed or refused to appear within a reasonable period of time, then that physician's name and address is listed as follows:

\_\_\_\_\_  
\_\_\_\_\_

**SECTION 7:** Transferring physician's certification. I certify that I have answered the above questions based upon the information available to me at the time of this individual's transfer.

Name of physician accepting transfer: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician's Signature: \_\_\_\_\_

Visit Sign within 15 minutes of Transfer:

Name: \_\_\_\_\_ SP: \_\_\_\_\_ P/N: \_\_\_\_\_ Resp. P/N: \_\_\_\_\_ Time: \_\_\_\_\_

SPID: \_\_\_\_\_

**TRANSFERRED INDIVIDUAL'S NAME**

Medical Record # \_\_\_\_\_

Original to Medical Records      Copy to Receiving Facility