Sample

Medical Center of __________ Memorandum of Transfer

______________________________, TX _____ ___-___-____

Patient Full Name: ____ DOB ____/____/_____

Medical Record Number: ____________________________ ☐ Male ☐ Female

Medical Condition

1. **Diagnosis**: ____
2. **Vital Signs at Time of Transfer: Time:** _____ : ____ am pm
   Temp: ________ HR: ________ Resp: _______ BP: ______ FHT:______

Reason for Transfer

3. **Patient Being Transferred for**:
   - ☐ Medical necessity/Upgrade in care:
   - ☐ STABLE at transfer ☐ Yes ☐ No
   - ☐ EMERGENCY transfer ☐ Yes ☐ No
   - ☐ Patient request
   - ☐ If Patient request, reason for request: ______________________________

   ____

   On-call physician refusing or failing to appear to provide stabilizing treatment. Name and address of refusing/failing on-call physician:
   Name:____
   Address: ____

Physician Certification

4. **Physician Certification**:
   I have explained the risks and benefits of transfer (or refusal of transfer) to the patient/legally responsible representative as follows:

   Summary of benefits of transfer: ☐ specialized treatment or care
   ☐ improved possibility of retaining life or limb ☐ continuity of care
   ☐ further medical exam ☐ imaging procedures not available here
   ☐ invasive procedures/testing not available here
   ☐ other: ____

   ____

   Summary of risks of transfer: ☐ death ☐ pain ☐ delivery in route
   ☐ worsening of condition ☐ motor vehicle accident
   ☐ loss of function of afflicted body part
   ☐ other: ____

   Based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of transfer to the patient, and in the case of labor, to the unborn child.

   Signature of Transferring Physician: ______________________________
   Date: ____/____/______ Time: ______ : ______ am pm

Patient Information

5. **Patient Information (*if known*)** :
   Address : ____

   ____

   Phone: ____________________________ Age: _____________
   Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other:_________________
   National Origin: ____________________Religion: _______________
   Physical handicaps: ____
6. **Date of First Arrival at Transferring Hospital**: ____/____/_________
   Time: _____ : _____ am pm
7. **Next of Kin Information (*if known*)**:
   Full Name: ____
   Address : ____
   ____________________Phone: _____ - _______ - ___________
   Notified: ☐ Yes ☐ No

First Contact with Accepting Facility

8. **First Contact with Accepting Hospital**:
   Date: ____/____/________ Time: _____ : _____ am pm
   Name of first contact at Accepting Hospital:_____________________________
   Name and title of person first calling Accepting Hospital: ________________

   ____

Accepting Facility, Administrator and Physician

9. **Transferring Hospital administrator's signature and title who called Accepting Hospital:**_________________________________
   Name: ________________________________ Time: ___ : ____ am pm
   Title: __________________________________ Date: ____/____/_______
10. **Accepting Hospital's name:**______________________________________
    Address: ____
    ____________________________Phone: ______ - ______ - _________
11. **Accepting Hospital was secured by Transferring Hospital:**
    Date: ____/_____/_______ Time: _____ : ____ am pm
    Name and title of Accepting Hospital administrator:

    ____
12. **Accepting Physician was secured by Transferring Physician**:
    Date: ____/____/_______ Time:_____ : ______ am pm
    Accepting Physician: ____
    Address: ____
    ______________________Phone: ______ - _______ - _____________
13. **Transferring Physician**: ____
    Address: ____
    ______________________Phone: ______ - _______ - ____________

Transfer Support

14. **Type of transferring vehicle and company used:**
    Name of company: ______________________________________
    Method of transfer: ☐ ground ambulance ☐ air ambulance
    ☐ private car ☐ police/sheriff ☐ BLS ☐ ALS ☐ MICU
    Time contacted: _____ : ____ am pm ETA: _____ : ______ am pm
    Personnel needed for transport: ☐ EMS ☐ R.T. ☐ Nurse ☐ Physician
    ☐ police/sheriff ☐ None ☐ Other:________________________________

    Support/Treatment Needed During Transfer:
    ☐ Cardiac Monitor ☐ IV Pump ☐Oxygen Liters (No.: __)
    ☐ Pulse Oximeter ☐ FHT ☐ IV Fluid (Rate: ________)
    ☐ Restraints (Type: ____________) ☐ None ☐ Other:________________
15. **Attachments:**
    ☐ x-rays ☐ physician progress notes ☐ ABGs
    ☐ lab reports ☐ nursing progress notes ☐ EKGs
    ☐ H &P ☐ medication record ☐ medication reconciliation form
    ☐ other: ____
16. Questions regarding medication reconciliation form should be directed to ____________________ or the transferring physician.

Patient Consent

17. **Solicitud del paciente o consentimiento de transferencia**
    Los riesgos y beneficios de transferencia me han sido explicados y he sido informado de las obligaciones de *Medical Center of*____ bajo EMTALA. Comprendo los riesgos y beneficios; los he considerado y autorizo mi transferencia a otro establecimiento médico. Bajo mi conocimiento y comprensión,
    - ☐ **Estoy de acuerdo y autorizo mi transferencia.**
    - ☐ **Me reúso a ser transferido.**
    - ☐ **Solicito ser transferido porque** ________________________

    ____

    ____

    Firma del paciente o representante legal responsable:

    ____

    Relación con el paciente: ____________________________________
    Testigo: ____
    Fecha: ____/____/_____ Hora: _____ : ______ am pm
18. **Objetos personales (marque todas las que apliquen)**
    - ☐ Enviados con la familia
    - ☐ Enviados con el paciente
    - ☐ Entregados a:_________________________________

Acknowledgement of Memorandum of Transfer – To be completed by Accepting Hospital

1. **Name of Accepting Hospital:** ____________________________________

   ____

   Address: ____
   Phone: ______ - _______ - ________
2. **Date of arrival:** ____/____/________ Time: _____ : _____ am pm
3. **Accepting Hospital administrator's signature:**

   ____

   Title: ____
   Date: ____/____/_______ Time: _____ : _____ am pm
4. **Accepting Physician assuming patient responsibility**
   Name: ____
   Address: ____
   Phone: _____- _______ - ___________
   Date: ____/_____/_______ Time: ___ : _____ am pm
   Accepting Physician's signature: ___________________________
5. **If response to transfer request was delayed beyond thirty (30) minutes, document the reason(s) for delay, including any time extensions agreed to by the transferring facility. Use additional sheet, if necessary.**

   ____