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. **Patient request or consent to transfer**
    The risks and benefits of transfer have been explained to me and I have been informed of Medical Center of _____'s obligations under EMTALA. I understand these risks and benefits; I have considered them and I consent to my transfer to another medical facility. With this knowledge and understanding,
    ☐ **I agree and consent to the transfer.**
    ☐ **I refuse the transfer.**
    ☐ **I request the transfer because** _____
    _____
    _____
    _____
    Signature of patient or legally responsible representative:
    _____
    Relationship to patient: _____
    Witness: _____
    Date: ____/____/_____Time: _____ : _____ am pm
18. **Personal Belongings (check all that apply)**
    ☐ Sent with family
    ☐ Sent with patient
    ☐ Given to: _____

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

Sample

Medical Center of _____ **Memorandum of Transfer**

_____, TX _____ ___-___-____

Patient Full Name: _____ DOB ____/____/_____

Medical Record Number: _____ ☐ Male ☐ Female

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.**
   _____