HealthPartners®

Patient Sticker

CERTIFICATION OF APPROPRIATE TRANSFER

PROVIDER

Code Status: ☐ Full Code ☐DNAR ☐Other: _____ **Transfer date:**

☐ **Non-Emergent Transfer:** This patient has been examined and an Emergency Medical Condition has not been identified.

☐ **Patient Stable:** No material deterioration of patient's condition is likely to result from or occur during transport.

☐ **Patient Unstable:** The patient has been stabilized to the best of the facility's ability, but there remains a risk that material deterioration of the patient's condition may result from or occur during transfer.

I. REASON FOR TRANSFER:

☐ Facility does not have the capabilities to render further examination and/or treatment. Describe necessary facilities and/or procedures available at receiving facility _____

☐ On-call provider refused or failed to respond within a reasonable period of time.

Provider name _____ Address _____

☐ Requested by patient (or person legally responsible and acting on their behalf). Reason given:_____

☐ Discharge to Skilled Nursing Facility or Hospice

II. FACILITY ACCEPTANCE:

Transfer from:_____ to _____ Unit/Room _____

Accepting Provider: _____Time:_____☐Verified appropriate treatment/personnel/space available

Is this the closest appropriate facility? ☐ YES ☐ NO **If no, please explain** _____

III. TRANSPORT:

☐ YES ☐ NO Transport by any means other than ambulance is contraindicated by the patient's medical condition

☐ YES ☐ NO Patient is bed confined (unable to: get up from bed without assistance, ambulate, or sit in a chair/wheelchair)

Medical condition: _____

Support/Treatment needed during transport: ☐ None ☐ Cardiac Monitor ☐ Pulse Oximeter ☐ Airway/vent management

☐ O2_____liters ☐ IV Meds/Fluids ☐ Restraints ☐ Positioning due to ortho device/injury ☐ Other_____

Mode of transport: ☐ BLS ☐ ALS ☐ Private Car ☐ Helicopter ☐ Neonatal Unit ☐Other:_____

Agency: ☐ Lakeview ☐SCEMS ☐ River Falls ☐ New Richmond ☐ Amery ☐ Allina ☐ Other:_____

IV. RISKS AND BENEFITS OF TRANSFER:

Medical Benefits: _____

☐ Obtain level of care/service not available at this facility

☐ Benefits outweigh risks of transfer

Medical Risks: _____

☐ Deterioration of condition en route _____

☐ Worsening of condition or death if you stay at this facility

I certify that the above information is true and correct based on my evaluation of this patient. Based upon the reasonable risks and benefits described above and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer. I also certify that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

*☐**If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows**:_____*

Transferring Provider Signature:_____ **Date/Time:** _____

Per _____(provider) by _____ (RN/Qualified Medical Personnel) Date/Time:_____

Printed name and credentials:_____

PATIENT

V. PATIENT CONSENT

☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the provider responsible for my care that the benefits to transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the provider's recommendation. I make this request upon my own suggestion and not that of the hospital, provider, or anyone associated with the hospital.

☐ I have been informed and I understand that the benefits of treatment at another facility outweigh the risks of transfer. In spite of understanding, I **REFUSE** to be transferred and I request that further examination and treatment be rendered at this facility.

Signature of ☐ Patient ☐ Responsible Person _____ Relationship_____

Witness_____ Date/Time:_____

RN/HUC

VI. DOCUMENTATION ☐ Certificate of Transfer Form ☐ Face Sheet ☐ Transfer/SNF & Home Care Form ☐ EMS report

NON EPIC FACILITY (all the above plus): ☐ Vital Signs ☐ Nursing Assessment/All Notes ☐ MAR/Med Rec ☐ X-Rays ☐ Labs

☐EKG ☐ MD Note/Dictated Report/H&P ☐ Advanced Directive ☐Other:_____

Report given to: _____ Date/Time:_____