**I. Reason for transfer:**

**II. Patient Condition (Check one of the following):**

- [ ] **Patient does not have an emergent medical condition.**
  
  This patient has been examined and does not have an emergent medical condition (includes severe pain, active labor, psychiatric disturbances or symptoms of substance abuse), such that the absence of immediate medical attention could result in serious jeopardy to the health of the individual or serious dysfunction of any bodily part or organ.

  **Note:** If this section applies, only page 1 of this form must be completed.

- [ ] **Patient has been stabilized**
  
  This patient has been examined, does have an emergent medical condition which has been stabilized such that, within reasonable medical probability, no material deterioration of this patient’s condition is likely to result from or occur during transfer.

  Medical Risks:

  Medical Benefits:

  **Note:** If this section applies, only page 1 of this form must be completed.

- [ ] **Patient has not been stabilized**
  
  This patient has been examined and does have an emergent medical condition which has not been stabilized.

  **Note:** If this section applies, the entire 2 page form (excluding section six) must also be completed.

**III. Receiving Facility (Complete all of the following):**

- [ ] The receiving physician has agreed to accept this patient at the receiving facility and provide appropriate medical treatment.

  Name of receiving physician: ___________________________ Time: __________________

- [ ] The receiving facility has available space, has qualified personnel for the treatment of this patient, has agreed to accept the transfer and shall provide appropriate medical treatment.

  Name of receiving facility: _____________________________ Time: __________________

  Person/title accepting for facility: ______________________ Time: __________________

  Nursing report given to: _____________________________ Time: __________________

**IV. Mode/Support/Treatment During Transfer (Complete Applicable Items):**

<table>
<thead>
<tr>
<th>Mode of transportation for transfer:</th>
<th>BLS Ambulance</th>
<th>ALS Ambulance</th>
<th>Helicopter</th>
<th>Private Car</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport Team</td>
<td>Other: ________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time: T_________P________R_________B/P_________02 Sat_________% RA 02 Initials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support /Treatment during transfer:</td>
<td>Cardiac Monitor</td>
<td>Oxygen - amt:</td>
<td>Pulse Oximeter</td>
<td>IV Pump</td>
</tr>
<tr>
<td>IV Type: ________________________</td>
<td>Rate: ________________________</td>
<td>Other: ________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_______ Patient ID applied _______ (location)</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**V. Accompanying Documentation (Check Appropriate Items):**

- [ ] Emergency Department Record
- [ ] Nurses Notes
- [ ] Lab Tests
- [ ] Medication Record
- [ ] History & Physical
- [ ] EKG
- [ ] X-Ray/Diagnostic Films
- [ ] Copy of Transfer Form
- [ ] Other: ________

**VI. Family Considerations:**

- [ ] Patient Belongings Given to Family
- [ ] Patient Belongings Transferred with Patient
- [ ] Name of Accepting Physician and Accepting Facility Info Given to Family
- [ ] Family Given Directions to Accepting Facility

**VII. Requests/Consents for Non-Emergent or Stable Patient (Complete Appropriate Items):**

This patient who does not have an emergent medical condition or whose medical condition has been stabilized acknowledges and understands the risks and benefits described in section I: requests consents to the transfer.

Signature of: [ ] Patient [ ] Responsible person: ________ Relationship: ________

Witness: ________ Second Witness: (If oral/telephone/patient mark) ________

[ ] Parent/Responsible person transporting the patient by private car has been instructed to go directly to accepting facility.

**SIGNATURES**

Physician: _____________________________ Nursing: _____________________________

WHITE – CHART   YELLOW – RECEIVING FACILITY   PINK – TRANSPORTATION

AUTHORIZATION FOR TRANSFER
### VIII. Medical Risks and Benefits - (Physician to complete appropriate items):

Medical Risks of Transfer: _______________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________

Medical Benefits of Transfer: _____________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________

Patient Refuses ☐ Examination ☐ Treatment ☐ Transfer with medical risks being: __________________________________________
_____________________________________________________________________________________________________________
______________________________________________________________________________________

### IX. Certification of Need for Transfer

I have examined this patient and based upon the reasonable risks and benefits described above and upon the information available to me, 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.

Certifying Physician: ________________________________ Signature: _____________________________

### X. Consent/Refusal (Complete all of the following):

This ☐ patient or ☐ responsible person acting on behalf of the patient having been informed of the risks/benefits of transfer transfer and/or the risks of refusal to examination, treatment and/or transfer as documented in Section VI above:
☐ Requests and/or ☐ Consents to transfer ☐ Refuses to consent to transfer ☐ Refuses examination ☐ Refuses treatment
Signature of:
☐ Patient ☐ Responsible person: ________________________________ Relationship: ________________________________
Witness __________________________ Second Witness: (If oral/telephone/patient mark) __________________________
☐ Parent ☐ Responsible person instructed to go directly to accepting facility
☐ If applicable, reason for request to transfer or refusal to transfer ______________________________________________________

### XI. Complete as appropriate

Name of any on-call physician who refused to see the patient or failed to appear within a reasonable time:
Name ________________________________
Address: ________________________________
Contacted by: ________________________________
Time of contact: ____________ Time of response: ____________

### XII. Signatures

If different than certifying physician, name and title of person(s) completing any section of this form.

______________________________
______________________________
______________________________
______________________________

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**美白 - 账单 黄色 - 收件方 粉色 - 运输**

**授权书**