DATE: TIME:

SECTION I: DEMOGRAPHICS

1. PATIENT'S NAME (Last Name, First Name, Middle Initials)	2. PATIENT'S DATE OF BIRTH (MM/DD/YYYY)

3. PATIENT HAS AN ADVANCE DIRECTIVE ☐ NO ☐ YES (send copy with patient)

4. EMERGENCY CONTACT INFORMATION

NAME OF CONTACT	RELATIONSHIP	TELEPHONE NUMBER

SECTION II: REASON FOR TRANSFER

1. NATURE OF SERVICES NEEDED BY PATIENT REQUIRING TRANSFER (Select all that applies)

☐ Diagnosis ☐ Consultation/Evaluation ☐ Return to healthcare facility
☐ Treatment ☐ Service Not available at GMHA facility ☐ Other: (Specify)
☐ Long Term Care ☐ No bed available at GMHA facility

2. DESCRIBE SERVICES NEEDED

SECTION III. TYPE AND LEVEL OF SERVICES REQUIRED

1. DIAGNOSIS

2. DESCRIPTION OF TREATMENT PRIOR TO TRANSFER ☐ Refer to H&P and progress note

3. DESCRIPTION OF FURTHER TREATMENT CONTEMPLATED ☐ Refer to discharge summary

4. LEVEL OF CARE PRIOR TO TRANSFER

☐ Emergency Department ☐ Intensive Care ☐ Telemetry ☐ Regular ☐ Long-Term (SNF)
☐ Outpatient ☐ Other (Specify):

SECTION IV - CONDITION OF PATIENT ON TRANSFER

1. IS PATIENT MEDICALLY STABLE FOR TRANSFER ☐ YES ☐ NO Details

2. IS PATIENT BEHAVIORALLY STABLE FOR TRANSFER ☐ YES ☐ NO Details

SECTION V - MODE OF TRANSPORTATION

1. DESCRIBE SPECIAL MODE AND STAFF REQUIREMENTS STAFF ESCORT ☐ MD ☐ RN ☐ RRT
2. IV MEDICATION OR OTHER TREATMENT ENROUTE

SECTION VI - INFORMATION TO BE SENT WITH PATIENT

☐ Complete medical records ☐ Discharge Summary ☐ Transfer Note ☐ ER Note
☐ Lab Results/Reports ☐ Imaging studies report ☐ ECG ☐ Consent to Transfer
☐ Advance Directive ☐ Other (Specify):

SECTION VII - PATIENT/FAMILY CONSENT RECEIVED (*Must be completed for every transfer of UNSTABLE PATIENTS*)

☐ PATIENT/FAMILY CONSENTS TO TRANSFER
(Send a copy with patient)

____ REFERRING PHYSICIAN CERTIFIES THAT BENEFITS OF
(initial) OUTWEIGHS RISK

Physician's Signature	DATE	TIME

SECTION VIII - RESPONSIBLE INDIVIDUALS

1. NAME OF TRANSFERRING PHYSICIAN AT GMHA FACILITY	2. TRANSFERRING/ACCEPTING FACILITY
3. NAME OF ACCEPTING PHYSICIAN AT ACCEPTING FACILITY	4. TELEPHONE NUMBER

SECTION IX - DECISION

☐ NOT ACCEPTED (Specify Reason)	☐ ACCEPTED, and TRANSPORTATION AUTHORIZED

NAME OF WARD TO TRANSFER TO	DATE AND TIME OF TRANSFER

NAME OF PHYSICIAN COMPLETING THIS FORM	PHYSICIAN SIGNATURE	DATE AND TIME