ATTACHMENT II

CERTIFICATE OF TRANSFER

I hereby certify that, based on the information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another medical facility outweigh the increased risk to the individual, and in the case of pregnancy, the patient is deemed stable for transfer and active labor which would make transfer contraindicated.

This certification is based on the following:
Reason for Transfer: ____

Benefits:
____
____
____

Risks:
____
____
____

All transfers have the inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle or aircraft.

Physician Name: ______________________

Physician Signature: ______________________ Date: __________ Time: __________

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CONSENT TO TRANSFER

I hereby consent to transfer to another medical facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made. I have considered these risks and benefits, including the ones set out above, and consent to transfer.

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agent and employees, from all responsibility for any ill effects which may result from my transfer.

Signature of Patient or Responsible Party: ______________________________

Relationship to Patient: ______________________________

Witness: ______________________ Date: ______________ Time: __________

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REFUSAL OF TRANSFER

I acknowledge that I have been examined, and that I have been offered to transfer to another medical facility. I have been informed of the risks and consequences involved in this refusal, the possible benefits of continuing medical treatment at this transfer hospital, and any realistic alternatives to my decision to refuse further examination and treatment/transfer.

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agent and employees, from all responsibility for any ill effects which may result from my refusal to transfer.

Signature of Patient or Responsible Party______________________________

Relationship to Patient: ______________________________

Witness: ______________________ Date: ______________ Time : __________

Certificate of Transfer
Guam Memorial Hospital Authority
Reviewed/Revised: NM 11/15 MEC 11/15 EMC 12/15 Approved HIMC 05/16
Form # 2016.004

Patient ID