(A) Policy Statement

Patients will be transferred to another hospital when the admission is not appropriate for the type of care provided at the University of Toledo Medical Center or when patients or physician request the transfer.

(B) Purpose of Policy

To assure acceptance of the patient at the referral facility. To assure the safe transport of the patient; to provide the mechanism for transfer of records in a confidential manner; to insure safe arrival of the patient.

(C) Procedure

1. The patient is evaluated by the attending physician, a medical screen is performed and steps are taken to stabilize the patient as necessary. The physician determines the need for the patient to transfer to another facility.

2. The facility to which the transfer is to be made is notified and the accepting physician is identified by the University of Toledo Medical Center (UTMC) physician.

3. The accepting facility agrees to admit the patient based on the information provided regarding the patient's medical need to be transferred to the facility, a determination by the transferring physician that the facility can provide the required specialty service, a physician on the medical staff accepts the patient, qualified personnel are available to provide the needed healthcare services, required therapeutic and diagnostic equipment is available to meet the patient’s needs, and facilities are available to accommodate the patient.

4. The patient and family will be informed of the impending transfer and the risks and benefits associated with the transfer. The patient and/or family must consent to the transfer in writing. (See attached form.)

5. Mode of transport, will be determined by the referring and accepting physicians.

6. Stabilization and care of patient during transport will be determined by the referring and accepting physicians.

7. A copy of the medical record will be sent, including the following:
   a. Transfer report;
   b. Operative report;
   c. Pathology report;
   d. Any testing;
   e. Consults; and
   f. History and physical.

The medical record will reflect:
   a. Initial and ongoing care to stabilize the patient prior to transfer
   b. A chronology of events that have taken place
   c. The treatment plan
   d. A description of the patient's response to treatments/medications/procedures
e. Results of the measures that have been taken to prevent further deterioration of the patient

8. The transfer report will include:
   a. Verification of the receiving facility to accept the patient;
   b. The name of the receiving facility;
   c. The consenting parties name and position of responsibility;
   d. The date and time of acceptance;
   e. Information given to receiving facility;
   f. The patient diagnosis;
   g. The patient's stabilized condition; and
   h. Name of the responsible physician/clinician at the hospital receiving the patient:
      1) If the receiving hospital is given medical information about the patient by someone other than the
         person who has requested the receiving hospital to accept the patient, both person's names should be
         documented.
      2) There should be a written record of the medical information that was transmitted to the receiving
         hospital and information describing responsibility for the patient during transfer and transport to the
         receiving facility.

9. Documentation to be completed in the transfer process includes:
   a. A legible copy of medical record;
   b. Transfer report notes as itemized in #8; and
   c. The interhospital transport consent.

10. Arbitrary transfer of a patient.
    a. No patient is transferred arbitrarily from UTMC.
    b. The following are not acceptable reasons for a patient transfer:
       3) Ability to pay or method of payment;
       4) Amount of time required for treatment;
       5) Transfer for reason of prognosis (i.e., critical, terminal);
       6) Immigration status; or
       7) Age, ethnicity, gender, religion, disabilities, socio-economic status, educational background, sexual
          orientation, gender identity, sex, race/color, creed, national origin or criminal status.

11. All personal belongings and valuable items will be sent with the patient.
# EMERGENCY DEPARTMENT
## AUTHORIZATION
### FOR TRANSFER

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
<th>DIAGNOSIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION I:
Reason for Transfer (check all that apply)
- [ ] Patient or private physician request
- [ ] The patient's condition is outside the capacity of the hospital's ability to provide care
- [ ] The patient has been stabilized and deterioration of the patient's condition is likely to result from transfers.
- [ ] The patient has not been stabilized, but the benefit of transfer outweighs the risk
- [ ] The transfer will be made with medical and other personnel as appropriate
- [ ] Other (describe)

### SECTION II:
Describe the expected benefits and risks of transfer (to be completed by a physician)

Physician Signature_________________________ Date:__________ Time:__________

### SECTION III:
Patient Signature or Patient Representative
Dr ____________________________ has explained the reason for my transfer to ____________________________ and has outlined the benefits and risk (if any) to me.

I consent to transfer.

Witness Signature_________________________ Patient Signature_________________________

The patient is unable to consent because ____________________________________________

Witness Signature_________________________ I therefore consent for the patient

Signature/Relationship_________________________

### SECTION IV:
If this patient is being transferred because an on-call physician failed or refused to appear in an appropriate time, then the physician's name is listed below.

Physician Name_________________________ Address_________________________

### SECTION V:
Transferring Physician's Certification

I certify that I have answered the above questions based upon the information available to me at the time of this individual's transfer

(Print Name of Physician Certifying Transfer)_________________________ Physician Signature_________________________ Date Time__________

---

ER001 Page 1 of 2 07/05
# Emergency Department Authorization for Transfer

## Communication

<table>
<thead>
<tr>
<th>Field</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s private physician’s name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring physician’s name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting physician’s name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verify bed at accepting facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMC person calling to verify bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMC person calling patient report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of person taking report</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Reason for Transfer

<table>
<thead>
<tr>
<th>Field</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient or family request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private physician request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent for transfer signed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do benefits of transfer outweigh the risk of transfer?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition on transfer: □ Good □ Fair □ Serious □ Critical</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Does patient require medical/nursing support during transport?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode of transport: □ Car □ BLS Amb □ ACLS Amb □ Mobile ICU Amb □ LS □ LF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family notified of transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Disposition of Clothing and Valuables

<table>
<thead>
<tr>
<th>Field</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Police</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Data Accompanying Patient

<table>
<thead>
<tr>
<th>Field</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Medical Record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Progress Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consult Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology Reports or Copies of Films</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG Copy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REMSNO, Ambulance or Other Transport Record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of RN ____________________________ Date: _________ Time: _________

Original to be retained with UTMC medical record

Copy to be sent with patient
**Precision Business Solutions 419.661.8700**  

**UMCT Order Form**

---

**Date:** ___________________

**Owner of Form:** ___________________

---

**Specifications**

**Form Description:** Emergency Department – Authorization for Transfer  
**Current Form Number:** ER001

---

**Print**

**Stock**

- [x] 20# White
- [ ] 60# Pastel ______
- [ ] 2 pt carbonless
- [ ] 3 pt carbonless
- [ ] 4 pt carbonless
- [ ] 5 pt carbonless
  - [ ] Other carbonless
- [ ] Other Stock__________
- [ ] Special Instructions (see below)

---

**Sides**

- [ ] Front
- [x] Front & Back

---

**Finishing**

**Padding**

- [ ] Top
- [ ] Left

---

**Unit Size**

- [x] 25 to a pack
- [ ] 50 to a pack
- [x] 100 to a pack
- [ ] Special Instructions (see below)

---

**Folding**

- [ ] Letter Fold
- [ ] Z Fold
- [ ] Special Instructions (see below)

---

**Drilling**

- [ ] Long edge std 3 holes
- [ ] Long edge 2 holes
- [x] Long edge 5 holes
- [ ] Long edge 7 holes
- [ ] Long edge 9 holes
- [ ] Short edge 2 holes
- [ ] Staple, Where ____________
- [ ] Special Instructions (see below)

---

**Packaging**

- [ ] Yes
- [ ] No

---

**Special Instructions:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________