MEDICINE LODGE MEMORIAL HOSPITAL & PHYSICIANS CLINIC

EMTALA Transfer Record

Patient Sticker

Medicine Lodge Memorial Hospital (MLMH)
710 North Walnut
Medicine Lodge, KS 67104
Tel: 620-886-3771 Fax: 620-930-3787

Certificate of Transfer:
This is to certify that an appropriate medical screening examination within the capability of the hospital / emergency department was performed at Medicine Lodge Memorial Hospital on _____, 20_____at _____(time) and necessary stabilizing treatment has been performed.

Patient Condition:
Based upon my examination of the patient and the information available at the time of examination, I certify that the benefits of transfer outweigh the risks.

- ❑ Emergent condition is STABILIZED; no reasonable likelihood of deterioration from or during transfer.
- ❑ Emergency condition persists despite best efforts / UNSTABLE. I certify that the benefits of transfer outweigh the risks.
- ❑ Patient is pregnant with contractions and / or bleeding / UNSTABLE.

Reason for Transfer:

- ❑ Specialty services and/or equipment are not available at MLMH.
- ❑ Patient/ legal guardian requests transfer. Services are provided at MLMH & offered but patient/guardian desires transfer.
- ❑ Patient requests transfer because insurance plan does not list MLMH as a covered facility.

Medical Benefits of Transfer:

- ❑ Receiving facility has resources, personnel, and equipment to provide higher level of care.
- ❑ Other:_____

Risks of Transfer:

- ❑ Death
- ❑ Bleeding
- ❑ Harm to self /others
- ❑ Delivery/Fetal Distress
- ❑ MI/Cardiac decompensation / arrest
- ❑ Pulmonary decompensation/arrest
- ❑ Decreased level of consciousness
- ❑ Vehicular accident/transport hazards
- ❑ Extension of Stroke / Paralysis
- ❑ Other_____

Discharge Disposition / Receiving Facility:

- ❑ Kansas Heart Hospital
- ❑ Via Christi / St Francis
- ❑ Wesley Medical Center
- ❑ Hutchinson Regional Medical Center
- ❑ Pratt Regional Medical Center
- ❑ Other:_____

Provider-to-Provider Approval of Transfer:
The Practitioner has spoken with the Physician and has agreed to accept the patient and provide appropriate medical services.

Dr. _____accepted transfer at: _____ (time)

Transferring & Reporting Practitioners Signature: _____Date:_____Time:_____

Patient Consent:
The risks and benefits of transfer have been explained to me. I understand the consequences associated with the transfer, therefore:

- ❑ I Consent to transfer
- ❑ I Refuse ambulance transfer. I will provide my own transportation to the above named receiving facility.
- ❑ I DO NOT CONSENT to transfer (complete AMA form)

_____ Patient Signature

_____ Signature of responsible person on behalf of patient

_____ Witness

_____ Witness

_____ Relationship of responsible person

Date:_____ Time:_____

Mode of Transport:
*Qualified personnel with appropriate medical equipment that will be able to use all necessary and appropriate life support measures will transfer the patient.

❑ * Ground Ambulance ❑ * Helicopter ❑ * Fixed Wing ❑ Private Vehicle ❑ Police Transport

Transport Provider:

❑ BCEMS	Time Contacted:_____	Time Arrived:_____	☐ Report given	Time Departed:_____
❑ Life Save	Time Contacted:_____	Time Arrived:_____	☐ Report given	Time Departed:_____
❑ Eagle Med	Time Contacted:_____	Time Arrived:_____	☐ Report given	Time Departed:_____
❑ Police	Time Contacted:_____	Time Arrived:_____	☐ Report given	Time Departed:_____

Additional Transport Staff:
❑ MD / DO ❑ APRN / PAC ❑ RN ❑ Paramedic ❑ Police ❑ N/A

Valuables / Belongings:
❑ Given to the Family. Circle / List: Home Meds, Glasses, Dentures, Wallet _____
❑ Sent with the patient. Circle / List: Home Meds, Glasses, Dentures, Wallet _____
❑ N/A

Healthcare Facility to Healthcare Facility Nurse Contact:
The receiving facility has agreed to accept the transfer, provide appropriate medical treatment and has available space and qualified personnel for the treatment of this patient.

Name of person accepting transfer: _____at _____(time). Bed Assignment:_____Nurse Initial:_____

RN/LPN Name: _____called report to:_____ at_____(time)

Vital Signs: Time:_____T:_____P:_____R:_____B/P:_____SpO_2:_____GCS:_____Pain:_____Nurse Initial_____

Transfer Records: (Send with Patient or Fax within 60 minutes)

	Sent	Faxed	N/A
Face Sheet	☐	☐	
Insurance Info	☐	☐	☐
Allergies /Reactions	☐	☐	☐
Home Med List	☐	☐	☐ (No home meds)
Provider ED Note	☐	☐	**Must be sent / faxed**
MAR / Meds given	☐	☐	☐ (None Given)
Lab done & Results	☐	☐	☐
EKG done & Results	☐	☐	☐
X-Ray done & CD	☐	☐	☐
CT done & CD	☐	☐	☐
Other Tests Done _____	☐	☐	☐
Other Test Results_____	☐	☐	☐

Nursing Documentation:

	Sent	Faxed	N/A
EHR Printed Report / Nurses Notes	☐	☐	
Oral Restrictions / NPO since:_____	☐	☐	☐
Catheters / IV	☐	☐	☐
Immobilizations (c-collar, spine, splint)	☐	☐	☐
Respiratory Support (Oxygen, BVM, BiPap)	☐	☐	☐
Impairments: (Hearing aide, Glasses)	☐	☐	☐
Other:_____	☐	☐	☐
EMTALA form (**copy**)	☐	☐	

Date:_____ Time Sent:_____ Staff Initials:_____
Date:_____ Time Faxed:_____ Staff Initials:_____

Emergency Contact Information: **None:** ☐
Name:_____Relationship:_____Phone #:_____
Name:_____Relationship:_____Phone #:_____

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