Memorial Hospital of Carbon County
TRANSFER FORM

This hospital is required by federal law to provide any presenting patient with a medical screen examination to determine whether an emergency medical condition exists and to provide necessary stabilizing care within its capabilities for emergency medical conditions without regard to means or ability to pay. This hospital does participate in Medicare and Medicaid (MediCal).

1. PATIENT CONDITION

A. [ ] There is little likelihood of or minimal risk of deterioration from or during transfer.

B. [ ] The patient may be at risk for deterioration from or during transfer.

C. [ ] Patient is Pregnant with contractions with minimal risk of deterioration during transfer to both mother and unborn child.

D. [ ] Patient is Pregnant with contractions with risk for deterioration from or during transfer to either the mother or unborn child.

4. All transfers have inherent risks of delays or accidents in transit, pain or discomfort upon movement, and limited medical capacity of transport units that may limit available care in the event of crisis. RISKS DURING TRANSFER

[ ] Death [ ] Risks to Unborn Fetus
[ ] Pain & Suffering [ ] Delay in Diagnosis
[ ] Permanent disability/disfigurement
[ ] Other: ____________________________

2. REASON FOR TRANSFER

A. [ ] For equipment or services not available at this facility: (list)

[ ] Other: ____________________________

B. [ ] Patient-initiated request for transfer. Services are available here and offered to patient, who wishes of their own volition and request to be transferred.

5. BENEFITS OF TRANSFER

[ ] Higher Level of care not available at MHCC
[ ] CT Scan, Radiological Imaging, Ultrasound
[ ] Surgeon, Specialist, OB/GYN
[ ] Neonatal Unit
[ ] Other: ____________________________

3. HOSPITAL ACCEPTANCE

A. Name of destination hospital:

[ ] Accepting MD:

NAME ____________________________________________

{ } initials of person obtaining acceptance

B. Accepting MD:

NAME ____________________________________________

{ } initials of person obtaining acceptance

C. Bedspace Confirmed:

NAME ____________________________________________

{ } initials of person obtaining acceptance

D. Report given to:

NAME ____________________________________________

{ } initials of person giving report

6. MODE OF TRANSPORT

[ ] ALS Ambulance
[ ] BLS Ambulance
[ ] Helicopter
[ ] Fixed Wing Aircraft
[ ] Other

[ ] Additional Personnel:

{ } RN { } Respiratory Therapist

{ } MD { } ____________________________________________

Service contacted: ____________________________

By ____________________________________________

Time __________________ ETA __________________

PHYSICIAN SIGNATURE RE: RISKS/BENEFITS

Based upon my examination of the patient and the information available to me at the time of transfer, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

RN Signature Date/Time

Physician Signature Date/Time
7. **PATIENT CONSENT TO TRANSFER**

I have been advised and understand the risks and benefits of my transfer. I also understand the need to release all relevant medical information and documents to the receiving physician/hospital.

[ ] I hereby CONSENT to transfer and release of Medical records

[ ] I hereby REFUSE transfer

Patient’s Signature (or on behalf of patient)  
Time

Witness: ____________________________

8. **PATIENT REQUEST TO TRANSFER AGAINST MEDICAL ADVICE**

I have been advised by the physician and staff of Memorial Hospital of Carbon County of the risks of being transferred and have been advised NOT TO BE TRANSFERRED. I am demanding transfer AGAINST MEDICAL ADVICE.

[ ] I hereby REFUSE treatment at Memorial Hospital of Carbon County and DEMAND transfer to another facility against medical advice.

Patient’s Signature (or on behalf of patient)  
Time

Witness: ____________________________

9. **PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN</td>
<td>DOB</td>
</tr>
<tr>
<td>SEX</td>
<td>WT</td>
</tr>
</tbody>
</table>

Personal Items sent with patient ( ) Y ( ) N

10. **CHART COPIES SENT**

Note: all originals must stay on the premises of this facility, only copies may be forwarded to transfer facility.

[ ] Face sheet 2 copies (1 faxed to Receiving Facility)

[ ] Insurance Information

[ ] Progress Notes

[ ] Physician Orders

[ ] Nurses Notes / CC Flow Sheet

[ ] Labs

[ ] X-ray

[ ] EKG

**SIGNATURE OF TRANSFERRING PHYSICIAN**

I have assured that sections 1-10 are accurately and correctly completed prior to transfer. I have fully explained all risks and benefits associated with this transfer (including those to the unborn child of pregnant mothers where applicable).

Physician Signature  
Date/Time

Physician Print Name

List items Sent:

__________________________

__________________________

__________________________

__________________________

__________________________

RN/EMT Signature  
Date/Time

Patient Sticker  
6/2017
Transfer Summary

Date ____________________________

Transfer Information:
Patient Name ____________________________ Diagnosis ____________________________


MHCC Attending Physician ____________________________

Date and Time Attending/Receiving Physicians Spoke ____________________________
Receiving Facility and Address/Phone #: ____________________________

MHCC Nurse called verbal treatment summary (prior to discharge)
To: (Name/Title) ____________________________ Date/Time ____________________________
Patient and/or Family Notified of Transfer: Yes/No ____________________________ Name ____________________________
If no, why not? ____________________________

Isolation Precautions None □ Contact □ Droplet □ Airborne □
Reason for Isolation Precautions ____________________________

Medical Records Sent
Face Sheet □ Nursing Notes □ Test/Procedures Performed □
Medication Reconciliation □ Test/Procedures Results □
History/Physical □ Medication Administration Record □

Allergies ____________________________

Current Therapy

IV/Access None □ Saline Lock/Peripheral IV □ PICC □ Other □

IV/Solutions/Drips Yes/No Describe: ____________________________

Foley Catheter: Yes/No Ostomy: Yes/No

Diet: NPO □ Other ____________________________

Infubation: Yes/No Vent Settings ____________________________ Oxygen ____________________________

Tubes: Yes/No Describe: ____________________________

Other: ____________________________

Surgery during present hospital stay ____________________________

Vital Signs: Time/Date ____________________________ Temp ______ B/P ______ HR ______ SpO2 ______

Resp ________ Pain ________

Neuro Assessment (if applicable): GCS Score ____________________________

Height ________ Weight ________ Weight reported to transporting agency □
Packet Completed By ____________________________ And reviewed by ____________________________

MHCC

Acute Care
Transfer Summary

Page 1 of 2
**Acute Care Transfer Summary (Continued)**

**Patient Has:**

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>None</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Speech</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Bladder Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Bowel Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Skin Condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Weight Bearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Immobilizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Sensation Impairment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Level of Activity:**
- Bed Rest □
- Chair □
- Stand □
- Walk □
- Needs Assistance □
- No Assistance □

**Patient's Mental Status:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alert and Oriented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Confused</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Wanderer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Aggressive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Withdrawn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Noisy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Uses:**
- Dentures □
- Glasses □
- Hearing Aid □
- Prosthesis □
- Wheel Chair □
- Walker □
- Cane/Crutches □

**Social Status:**
- Family/Contact Person __________________________ Phone # __________
- Lives With Others □
- Lives Alone □
- Followed by Home Health Nurse □
- SNF □

**Patient's Belongings:**
- Sent with Patient □
- Sent with Family □

**Additional Comments:**

________________________

________________________

________________________

________________________

________________________

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________________________

________________________
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th># of Transfers</th>
<th>Yes or N/A</th>
<th>No</th>
<th>Met</th>
<th>Not Met</th>
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</thead>
<tbody>
<tr>
<td>EDTR1</td>
<td>administrative (i.e. pre-transfer) communication elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR2</td>
<td>patient information elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR3</td>
<td>vital signs elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR4</td>
<td>physician or mid-level practitioner generated information elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR5</td>
<td>medication information elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR6</td>
<td>nurse generated information elements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDTR7</td>
<td>procedures and tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ED Transfer Communication Measure Data Collection Tool

CMS Certified Number (CCN):__________________________________________

Name of State:____________________________________________________

Patient’s Name:___________________________________________________

Patient Medical Record Number:____________________________________

Select Patient Discharged Disposition (Select one option)

_______ Hospice- Health Care Facility

_______ Acute Care Facility- General Inpatient

_______ Acute Care Facility- Critical Access Hospital

_______ Acute Care Facility- Cancer Hospital or Children’s Hospital

_______ Acute Care Facility- Department of Defense or Veteran’s Administration

_______ Other Health care facility

Date of Patient Encounter: ___/___/____ Date of Patient Encounter: ___/___/____

NOTE: Prior to completing the data collection tool, please reference the Emergency Department Transfer Communication Measures Data Collection Guide for detailed descriptions of each element. Does the medical record documentation indicate that the following communication occurred prior to departure of the patient from ED to another healthcare facility?

Nurse to Nurse Communication: __Yes __No Provider to Provider Communication: __Yes __No

Does the medical record documentation indicate that the following patient information went with the patient or was communicated via fax or Internet/EHR connection availability within 60 minutes of the patient’s discharge?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Emergency Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Insurance Information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Does the medical record documentation indicate that the following patient's vital signs were taken and the information went to the patient or was communicated by fax, phone or EHR connection availability within 60 minutes of the patient's discharge?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2 Saturation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological Assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the medical record documentation indicate that the following patient's medication information went with the patient or was communicated via fax or phone or EHR connection availability within 60 minutes of the patient's discharge?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administered in ER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies/ Reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History and Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for Transfer/POC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the medical record documentation indicate that the following nurse generated information that went with the patient or that it was communicated via fax or phone or EHR connection availability within 60 minutes of the patient's discharge?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory Impairments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immobilizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Restrictions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or EHR availability within 60 minutes of the patient's discharge?

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tests/Procedures Performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests/Procedures Results</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ER Disposition and Transfer Flowsheet

**Patient:** PATIENT, TEST  **Provider:** DOCTOR, PRACTICE  **Visit:** 0104371  **MR#:** 0009566

---

#### Patient Status at Time of Transfer:

- **Airway:**
  - [ ] Patent
  - [ ] Intubated
  - [ ] N/A

- **Breathing:**
  - [ ] Normal
  - [ ] Dyspnea

- **Time of Last Oral Intake:** 5/21/2019 11:00

- **Oral Restrictions:**
  - [ ] Yes
  - [ ] No
  - [ ] N/A

- **Circ IV:**
  - [ ] RA #:
  - [ ] LA #:

- **LOC:**
  - [ ] C-Collar
  - [ ] Neck Immob.

- **Immobilizations:**
  - [ ] Scoop
  - [ ] N/A

- **Procedures:**
  - [ ] NG
  - [ ] Chest Tube Rt
  - [ ] Foley
  - [ ] N/A

- **Other:**

---

#### Orders To Be Carried Out During Transfer:

- [ ] "IV Fluids"
- [ ] "Pain Control"
- [ ] "Antibiotics"
- [ ] "Other:

---

#### Mode of Transfer Information:

- **Transferred To:**
  - [ ] Billings Clinic Hosp.
  - [ ] St. Vincent Hosp.
  - [ ] Cody Regional Health
  - [ ] Big Horn County Jail
  - [ ] "Washakie Memorial Hospital"
  - [ ] "Wyoming Medical Center"
  - [ ] "Wyoming Retirement Center"
  - [ ] "North Big Horn Hospital"
  - [ ] "Other:"

- **Via:**
  - [ ] Cody Regional Health Ambulance Service
  - [ ] Private Vehicle
  - [ ] Air
  - [ ] N/A

- **Contacted By:**

- **Transport Arrival Time:**

- **Transport Depart Time:**

---

#### Transfer Acceptance Information:

- **Physician to Physician Communication**
  - **Transferring Physician:**
  - **Accepting Physician:**
  - **Comm. Means:**
    - [ ] Fax
    - [ ] Phone
  - **Comm. Date:**
  - **Comm. Time:**
  - **Accept Date:**
  - **Accept Time:**

- **Nurse To Nurse Communication To Receiving Facility**
  - **Transferring Nurse:**
  - **Receiving Nurse:**
  - **Comm. Date:**
  - **Comm. Time:**
  - **Records Sent:**
  - **Records Sent:**
  - **V/S Given?**
    - [ ] Yes
    - [ ] No

---

### Nurse Signature

- **Date:**
- **Time:**

---

### Receiving EMT Signature

(Acknowledges receipt of report and listed belongings)

- **Date:**
- **Time:**

---
Reason For Transfer/ Benefits and Risks of Transfer

Reason For Transfer:
- Need for Higher Level of Care Not Available at this Hospital
- Need for Diagnostic Equipment Not Available at this Hospital
- Patient/Responsible Party Request
- Other Reason for Transfer: __________________________

Risks of Transfer:
- Death
- Vehicular Accident/Transportation Hazards
- MI/Cardiac Decompensation
- Pulmonary Decompensation
- Bleeding
- Deterioration of Medical Condition
- Additional Delay in Receiving Appropriate Treatment
- Other Risk: __________________________

Provider Certification

By Signing Below, I certify that based upon the information available at the time of transfer, the medical benefits reasonably expected from transfer and treatment at the accepting facility, outweigh the increased risks, if any, to the patient or in the case of pregnancy, the unborn child. I also certify I have communicated the risks and benefits to the patient that were known to me at the time of transfer.

__________________________
Physician Signature

__________________________
Date:

__________________________
Select a date [13]

__________________________
Time:

Consent To Transfer and Release of Information

Consent To Transfer:

I understand that there are certain risks involved in all events of life including medical transfers such as this. My Health Care provider has informed me of the medical risk of transfer, including the fact that during the period of transport, I am not within any hospital, and any emergency occurring during transport can only be treated by the personnel and equipment carried in the transfer vehicle until arrival at the hospital.

If this is an emergency transfer, I understand my Health Care Provider believes, based on currently available information, that the risks of not being transferred are greater than the risk of transfer.

I understand that risk of all transfers include the risk of transfer vehicles being involved in accidents or other conditions that could produce future medical injury and a delay in transport and treatment.

Consent For Release of Information

I authorize Release of Clinical information referring Physician and facilities for the purpose of continued health care:

Considering these facts, I hereby consent to transfer.

__________________________
Date: 5/21/2019 [13]

__________________________
Time: __________________________

__________________________
Patient or Guardian Signature:

__________________________
Relationship to Patient (If Not Self): __________________________
Report to Long Term Care Facility:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Patient Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Dx.</th>
<th>Code Status</th>
<th>Allergies &amp; Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Discharge Diagnosis:</th>
<th>Reason for discharge</th>
</tr>
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<tbody>
<tr>
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<table>
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<tr>
<th>Care Need</th>
<th>Long Term Care</th>
<th>Rehabilitation</th>
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<table>
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<tr>
<th>Diet order:</th>
<th>Behavior/Cognition:</th>
<th>Activity order:</th>
<th>Assistive devices:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neurological Assessment</td>
<td></td>
<td>Immobilization (cast/braces)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin issues</th>
<th>yes</th>
<th>no</th>
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<tr>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Location:</th>
<th>Wound care needed</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Greater than stage 1</th>
<th>will need physician order</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Immunizations given:</th>
<th>Pain medication dose and time given:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antibiotics, dose and time given:</th>
<th>How many more doses:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anticoagulant, dose and time:</th>
<th>Last INR date and result:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Next INR due:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next Lab test due:</th>
<th>Other Tests:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal belongings sent with patient:</th>
<th>Sensory</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ dentures, □ glasses, □ hearing aids, □ TED hose, □ watch, □ cell phone, □ jewelry, other items list:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Discharge &amp; Admit order attached</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow up Appointment Date</th>
<th>Time</th>
<th>With whom</th>
</tr>
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<table>
<thead>
<tr>
<th>Vital Signs Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>P</td>
</tr>
<tr>
<td>SaO2</td>
<td>via</td>
</tr>
<tr>
<td>WT</td>
<td>lbs</td>
</tr>
</tbody>
</table>

| Respiratory Support | |
|---------------------| |

<table>
<thead>
<tr>
<th>Pain Level and Location:</th>
</tr>
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<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>Blood Sugar and time done:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Insulin type, dose and time given:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Continent Bladder:</th>
<th>yes</th>
<th>no</th>
</tr>
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<tr>
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<table>
<thead>
<tr>
<th>Foley:</th>
<th>yes</th>
<th>no</th>
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<table>
<thead>
<tr>
<th>Continent Bowel:</th>
<th>yes</th>
<th>no</th>
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<tr>
<th>Date of last BM:</th>
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</table>

<table>
<thead>
<tr>
<th>Attach copy of all results/reports:</th>
</tr>
</thead>
<tbody>
<tr>
<td>€ MAR - Medical Record</td>
</tr>
<tr>
<td>€ Lab Results</td>
</tr>
<tr>
<td>€ Radiology Results</td>
</tr>
<tr>
<td>€ Discharge Summary or last progress note</td>
</tr>
<tr>
<td>€ Medication List with provider signature</td>
</tr>
<tr>
<td>€ RX's for all new medications, any narcotic medications, all future orders for lab tests, radiology tests, therapies, and wound care</td>
</tr>
<tr>
<td>€ Face Sheet - Address, Patient Contact, Insurance</td>
</tr>
<tr>
<td>€ Copy of this Form</td>
</tr>
<tr>
<td>€ Patient Representative Notified of Discharge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report called to Healthcare Facility</th>
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<table>
<thead>
<tr>
<th>Date and Time of Report</th>
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<tr>
<th>Nurse Calling Report</th>
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EO4/23/2019
CONSENT FOR TRANSFER / REQUEST TO TRANSFER / CERTIFICATION FOR TRANSFER

HOT SPRINGS COUNTY MEMORIAL HOSPITAL
150 E ARAPAHOE ST., THERMOPOLIS, WY 82443

BE COMPLETED BY THE PHYSICIAN/QUALIFIED MEDICAL PERSONNEL

PATIENT CONDITION ON TRANSFER
☐ Stable for Transfer
☐ Unstable

RISK OF TRANSFER
1. Medical condition could worsen during transport
2. Transportation risk
3. Delay in treatment due to transfer
4. Other (NONE, if not checked):

BENEFIT OF TRANSFER
☐ Availability of higher specialized level of care (e.g., trauma, neonatal, ICU)
☐ Available capacity (e.g., qualified staff, beds, equipment) not currently available at this facility
☐ Continuity of care
☐ Other (NONE, if not checked):

REFUSAL OF TRANSFER

Transported By:
☐ Air Transport
☐ ALS
☐ BLS
☐ POV
☐ Other

CERTIFICATION OF TRANSFER

Certifying Physician or Qualified Medical Person Signature
Date
Time

To be signed only when the patient is unstable and the physician is not physically present at the time of transfer.

have discussed the risks and benefits of the transfer of this patient with the Qualified Medical Person. I agree with the certification.

Signature of Transferring Nurse
Date
Time

Signature of Physician (Must be Countersigned Within 24 Hours)
Date
Time

BE COMPLETED BY NURSE

ACCEPTING FACILITY

Physician to Physician Report Time

Accepting Facility

Accepting Facility Staff Name

Time Contacted:

Healthcare to Healthcare Connection

Transferring Facility
Hot Springs County Memorial Hospital, Thermopolis, WY

Transferring Physician Name (Print):

Transferring Nurse Name (Print):

Transferring Nurse Signature:

Documented:
☐ Lab & EKG Results
☐ Radiographs
☐ Discharge Summary
☐ Progress Notes
☐ Transfer Form

BE COMPLETED BY PATIENT

PATIENT CONSENT TO TRANSFER / REQUEST TO TRANSFER

I consent / request to be transferred because:
☐ I require specialty services that are not currently at this facility.
☐ Continuity of care
☐ The physician determined that my condition is stable for transfer. I want the cost of further treatment to be covered by my health plan.
☐ I elect transport by privately owned vehicle. The physician has recommended transfer by emergency medical services and has explained to me the risks of transport by privately owned vehicle.
☐ Other (NONE, if not checked):

I have been informed of and understand the risks and benefits of transfer as set forth above. I understand that the hospital is required to stabilize my emergency condition unless I request to be transferred to another facility OR the physician certifies that the medical benefits reasonably expected to be received at the other facility outweigh the risks of the transfer.

Patient / Parent / Agent or Surrogate Signature
Witness Signature
Date
Time
Weston County – Under records, JoAnn will note anything not done/sent.
ED Transfer Communication Measure Data Collection Tool

CMS Certified Number (CCN): ____________________________

Name of State: _______________________________________

Patient Name: ________________________________________

Patient Medical Record Number: _________________________

Select Patient Discharged Disposition: (Select one option)

_____ Hospice – healthcare facility
_____ Acute Care Facility – General Inpatient Care
_____ Acute Care Facility – Critical Access Hospital
_____ Acute Care Facility – Cancer Hospital or Children’s Hospital
_____ Acute Care Facility – Department of Defense or Veteran’s Administration
_____ Other health care facility

Date of Patient Encounter: ______/_____/_________ (MM-DD-YYYY)

Date of Data Collection: ______/_____/_________ (MM-DD-YYYY)

NOTE: Prior to completing the data collection tool, please reference the Emergency Department Transfer Communication Measures Data Specifications Manual for detailed descriptions of each data element.

Does the medical record documentation indicate that the following communication occurred prior to departure of the patient from ED to another healthcare facility?

1. Healthcare Facility to Healthcare Facility Communication:

_____ Yes _____ No

2. Physician/Advanced Practice Nurse/Physician Assistant (Physician/APN/PA) Physician/APN/PA communication:

_____ Yes _____ No _____ N/A
10. Respiratory Rate:

_____Yes______No

11. Blood Pressure:

_____Yes______No  _____N/A

12. Oxygen Saturation:

_____Yes______No

13. Temperature:

_____Yes______No  _____N/A

14. Neurological Assessment:

_____Yes______No  _____N/A

Does the medical record documentation indicate that the following patient’s medical information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge?

15. Medications Administered in ED:

_____Yes______No

16. Allergies/Reactions:

_____Yes______No

17. Home Medications:

_____Yes______No
25. Oral Restrictions:

____ Yes ______ No ______ N/A

Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge?

26. Tests/Procedures Performed:

____ Yes ______ No ______ N/A

27. Tests/Procedures Results:

____ Yes ______ No ______ N/A