



GUIDELINES FOR TRANSFERRING PATIENTS FROM EMERGENCY DEPARTMENT

1. Notify receiving facility by telephone; then document the time, name of person contacted at receiving facility and name of person at VAMC (VA Medical Center) who made the call.
2. Confirm that physician to be responsible for the patient's care at the receiving facility has been contacted. Document time and name of person who made the call (this should be a physician.)
3. Document the reason patient is being transferred (patient request, no beds, etc.)
4. Make photocopies of all Emergency Department records and send with the patient to receiving facility.
5. Sign transfer form after all above are completed; attach copy of records going with patient to receiving facility. Retain original with hospital records.

TO BE COMPLETED FOR EVERY TRANSFER REQUEST TO AND FROM A VA MEDICAL FACILITY

SECTION I - DEMOGRAPHIC AND ELIGIBILITY INFORMATION

1. VETERAN'S LAST NAME- FIRST NAME- MIDDLE INTIAL		3. ADDRESS	
<input type="text"/>		<input type="text"/>	
2. SOCIAL SECURITY NO.	<input type="text"/>		
4. DATE AND TIME	<input type="text"/>		
5. ELIGIBILITY FOR VA CARE		7. ELIGIBILITY FOR TRAVEL/SPECIAL MODE	
<input type="text"/>		<input type="text"/>	
8. PATIENT HAS ADVANCED DIRECTIVE <input type="radio"/> YES <input type="radio"/> NO <i>(If Yes send copy with patient)</i>			
9A. NAME OF CONTACT	9B. TITLE OF CONTACT	9C. TELEPHONE NUMBER	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

NOTE: PHYSICIAN IS TO COMPLETE THE REMAINDER OF THIS FORM

SECTION II - REASON FOR TRANSFER

1. NATURE OF SERVICES NEEDED BY PATIENT REQUIRING TRANSFER *(Identify)*

<input type="checkbox"/> DIAGNOSIS	<input type="checkbox"/> RETURN TO PRIMARY HEALTH FACILITY	<input type="checkbox"/> SERVICE NOT AVAILABLE AT REFERRING FACILITY
<input type="checkbox"/> TREATMENT	<input type="checkbox"/> CONSULTATION/EVALUATION	<input type="checkbox"/> NO BED AT REFERRING FACILITY
<input type="checkbox"/> LONG TERM CARE	<input type="checkbox"/> OTHER (Specify) <input type="text"/>	

2. DESCRIBE SERVICES NEEDED

SECTION III - TYPE AND LEVEL OF SERVICES REQUIRED

1. DIAGNOSIS

2. DESCRIPTION OF TREATMENT PRIOR TO TRANSFER

3. DESCRIPTION OF FURTHER TREATMENT CONTEMPLATED

4. LEVEL OF CARE PRIOR TO TRANSFER (ER, Outpatient, Ward, ICU etc.)

1. VETERAN'S NAME	2. SOCIAL SECURITY NO.
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SECTION IV - CONDITION OF PATIENT ON TRANSFER

1. IS PATIENT MEDICALLY STABLE FOR TRANSFER <input type="radio"/> YES <input type="radio"/> NO	DESCRIBE (e.g. vital signs, significant history, physical findings, mental status, airway status, lab tests etc.) <div style="border: 1px solid black; height: 60px;"></div>
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1. IS PATIENT BEHAVIORALLY STABLE FOR TRANSFER <input type="radio"/> YES <input type="radio"/> NO	DESCRIBE <div style="border: 1px solid black; height: 60px;"></div>
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SECTION V - MODE OF TRANSPORTATION

1. DESCRIBE SPECIAL MODE AND STAFF REQUIREMENTS

2. IV MEDICATIONS OR OTHER TREATMENTS ON ROUTE

SECTION VI - INFORMATION TO BE SENT WITH PATIENT

COMPLETE MEDICAL RECORD
 DISCHARGE SUMMARY
 TRANSFER NOTE
 ER NOTE
 CLINIC NOTE
 OTHER (*Imaging studies, laboratory reports, EKGs, etc.*)

SECTION VII - PATIENT/FAMILY CONSENT RECEIVED (*Must be completed for every transfer of an unstable patient.*)

<input type="checkbox"/> PATIENT CONSENTS TO TRANSFER	<input type="checkbox"/> REFERING PHYSICIAN CERTIFIES THAT BENEFITS OF TRANSFER OUTWEIGH RISKS
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SIGNATURE:

SECTION VIII - RESPONSIBLE INDIVIDUALS

1. NAME OF TRANSFERRING/RECEIVING PHYSICIAN AT THIS FACILITY	2A. TRANSFERRING /ACCEPTING FACILITY FACILITY
2B. NAME OF PHYSICIAN	2C. TELEPHONE NUMBER

SECTION IX - DECISION (*To be completed for all transfer requests into a VA facility.*)

<input type="checkbox"/> 1. NOT ACCEPTED (<i>Specify reason</i>)	<input type="checkbox"/> 2. ACCEPTED (<i>Complete items 2A t hrough 2H below</i>)

2A. NAME AND WARD OF VA ACCEPTING PHYSICIAN	2B. DATE AND TIME OF TRANSFER	
2C. TRANSPORTATION AUTHORIZED. <input type="radio"/> YES <input type="radio"/> NO	2D. NON-VA MEDICAL SERVICES AUTHORIZED. <input type="radio"/> YES <input type="radio"/> NO	
2E. NAME AND SIGNATURE OF PHYSICIAN COMPLETING THIS FORM	2F. TELEPHONE NUMBER	2G. DATE AND TIME



PATIENT'S NAME:

PATIENT'S SSN:

FACILITY

[Empty text box for Patient's Name]

[Empty text box for Patient's SSN]

[Empty text box for Facility]

In my medical opinion, this patient does not have an emergency medical condition or the condition has been stabilized.

Physician's Signature

Date

Time

If an emergency condition exists, the responsible physician must sign the following certification prior to transfer.

The patient does not request transfer, but it is my opinion, based on the information available to me at this time, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the risks of the transfer. (Any facility transferring patients with unstabilized medical conditions must provide medical treatment, within its capacity, to minimize the risk to the individual; send all pertinent medical records, including advanced directives; effect the transfer using qualified personnel and equipment; and obtain consent of the receiving facility.)

ADDITIONAL COMMENTS

[Empty text box for Additional Comments]

Physician's Signature

Date

Time

CONSENT TO TRANSFER

I consent to be transferred to

Name of Facility

I have been informed of the benefits and risks of this transfer. The most significant risks are:

[Empty text box for Risks]

Patient's Signature

Date

Time

Witness's Signature

Date

Time