SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

INTER-FACILITY TRANSFER CONSENT FORM

I. TRANSFER REQUEST BY UNSTABILIZED PATIENT

I acknowledge that my medical condition has been evaluated and explained to me by _____
NAME OF PHYSICIAN

who has recommended and offered to me further medical examination and treatment and has informed me of the hospital obligation to provide stabilizing treatment.

The potential benefits of such further medical examination and treatment as well as the potential risks associated with transfer to another facility have been explained to me and I fully understand them. In spite of this understanding, I refuse to consent to the further medical examination and treatment that has been offered to me and request transfer to:

_____
NAME OF RECEIVING FACILITY

_____ _____ _____
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE INDIVIDUAL SIGNING ON THE PATIENT'S BEHALF | RELATIONSHIP TO PATIENT | DATE/TIME

II. TRANSFER CONSENT

I acknowledge that my medical condition has been evaluated and explained to me by _____
NAME OF PHYSICIAN

who has recommended that I be transferred to the service of _____
NAME OF ACCEPTING PHYSICIAN

at _____
NAME OF RECEIVING FACILITY

The potential benefits of such transfer, the potential risks associated with such transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.

_____ _____ _____
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE INDIVIDUAL SIGNING ON THE PATIENT'S BEHALF | RELATIONSHIP TO PATIENT | DATE/TIME

III. TRANSFER REFUSAL

I acknowledge that my medical condition has been evaluated and explained to me by _____
NAME OF PHYSICIAN

who has recommended that I be transferred to _____
NAME OF RECEIVING FACILITY

The potential benefits of such transfer, the potential risks associated with such transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. Even though the above named physician believes it is my best interest to be transferred, I refuse to be transferred and I request to continue receiving treatment at this institution.

_____ _____ _____
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE INDIVIDUAL SIGNING ON THE PATIENT'S BEHALF | RELATIONSHIP TO PATIENT | DATE/TIME

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INTER-FACILITY TRANSFER RECORD

Receiving Hospital	Name/Title of Accepting MD	Date

Name of Contact Person	Title	Telephone #

Patient's Name (Last) (First)	Sex	DOB	Medical Record #

Address	Apt.	City	State	Telephone #

Next of Kin (Name)	Relationship	Telephone #	Notified
			☐ Yes ☐ No

Reason for Transfer

☐ Bed Unavailable ☐ Patient/Family Request ☐ Insurance Request ☐ Service Not Available (Specify Transfer Reason):_____

MEDICAL SUMMARY

Diagnosis

Medical History (include allergies, medications taken)

Physical Findings and Treatment (including medications, IV fluids, and blood administered, lab and X-ray results, procedures done)

Documents Sent with Patient

☐ X-Rays ☐ Lab Reports ☐ Transfer Consent Form ☐ Copy ER Chart

Patient's Condition at Transfer

☐ Critical ☐ Serious ☐ Fair ☐ Good

Authorization for Transfer

The patient has been stabilized such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during the transfer. (A patient in active labor has been stabilized if she has delivered, including the placenta.)

☐ Patient (or legally responsible individual acting on the patient's behalf) consents to the transfer. **Transfer Consent Form** must be completed.

MD Approval _____ SIGNATURE _____ TITLE _____ DATE

Administrator/ Nursing Supervisor _____ SIGNATURE _____ TITLE _____ DATE

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SD134 White Copy - MEDICAL RECORD Yellow Copy - SENT WITH PATIENT Pink Copy - NURSING OFFICE