Patient Transfer Order Form

MyMichigan Health

INFORMATION TO BE SENT WITH THE PATIENT		
□ Complete Medical Record	□ Medications	□ H&P
□ Lab work	□ Discharge Summary	□ EKG
□ Progress Notes	□ Completed transfer form	□ Follow local process for pushing radiology images

SENDING FACILITY INFORMATION	
SENDING FACILITY:	SENDING PROVIDER:
ADDRESS:	CONTACT PHONE:

RECEIVING FACILITY INFORMATION			
RECEIVING FACILITY NAME:	ACCEPTING PROVIDER (Required):	TIME CONTACTED	BED NUMBER (Required):

MEDICAL CONDITION & LEVEL OF SERVICES REQUIRED

DIAGNOSIS/REASON FOR TRANSFER:

CONDITION: ☐ Stable ☐ Other: _____

☒ PROTOCOLS: To follow MCA Protocol 8-15

☐ Cardiac Monitoring ☐ External Fetal ☐ Art Line ☐ High Flow Oxygen ☐ Temperature Management ☐ Chest Tube

☐ Other:_____

☐ I & O ☐ NG to _____suction ☐ O_2 at _____L/min via _____

OTHER MEDICATIONS ENROUTE:

IV:	**#1**	
	#2	
	#3	

VENT:		SIMV/AC		Peep		Pressure	☐	Vent setting can be titrated to patient condition
		FiO_2		Tidal Volume		RR		

OTHER ORDERS:

MODE OF TRANSPORTATION

AGENCY TRANSFERRING:

TRANSER VIA ☐ Ambulance BLS ☐ Ambulance ALS ☐ Ambulance Critical Care ☐ Helicopter ☐ Other _____

Provider Certification The receiving facility has agreed to accept transfer, provide space and qualified personnel, and to provide appropriate medical treatment.

I have examined the patient and explained the following risks and benefits of being transferred/refusing transfer to the patient.

Risk/Benefits:	

Based on these reasonable risks and benefits to the patient and/or the unborn child(ren), and based upon the information available at the time of the patient's examination, I certify that the medical benefits reasonably to be expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to the individual's medical condition from affecting the transfer.

Provider Signature:		Date/Time:	

This form must be filled out for transfer to accepting facility with information prior to or with transfer.

Order

Patient Name:_____

Patient DOB:_____

Encounter Date:_____