HARTFORD HOSPITAL EMTALA CONSENTS

CONSENT TO TRANSFER AS RECOMMENDED BY
HARTFORD HOSPITAL PROVIDER

Basis for Transfer Recommendation
The patient’s condition requires the following specialized care, facilities, and/or resources not available at Hartford Hospital:

| Type of care, facilities, and/or resources required | Signature of HH provider recommending transfer |

Patient’s Consent to Transfer
I have been informed of my rights regarding examination, treatment, and transfer. I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical professional and/or my private physician, who has recommended that I be transferred to the care of:

__________________________ at ____________________________
Name of individual accepting transfer Name of receiving facility

The reason for the transfer, the potential benefits of transfer, and the probable risks of not being transferred have also been explained to me, and I fully understand them. I therefore agree and consent to be transferred.

__________________________
Signature of patient or legally authorized representative

__________________________
Witness

__________________________
Relationship to patient

Date ________________ Time ________________

Patient’s Refusal to be Transferred
I have been informed of my rights regarding examination, treatment, and transfer. I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical professional and/or my private physician, who has recommended that I be transferred to:

__________________________
Name and/or type of recommended receiving facility

The reason for the transfer, the potential benefits of transfer, and the probable risks of not being transferred have also been explained to me, and I fully understand them. Although I have been told it is in my best interest to be transferred, I refuse to be transferred and request instead to continue receiving treatment at Hartford Hospital.

__________________________
Signature of patient or legally authorized representative

__________________________
Witness

__________________________
Relationship to patient

Date ________________ Time ________________

Unavailability of Consent

_____ Patient is unable to give informed consent, and there is no legally authorized representative available to give informed consent.

_____ Patient is being committed involuntarily.

Patient accepted in transfer to ____________________________ by ____________________________
Name of receiving facility Name of individual accepting transfer
PROVIDER’S CERTIFICATION OF TRANSFER PROCEDURES
(Complete both sides)

Date of transfer: _______________________

Patient’s Condition at Time of Transfer

Stable

___ Patient is stable at time of transfer. Within reasonable medical probability, no material deterioration of the patient’s condition is likely to occur during or as a result of transfer.

Unstable

___ Patient remains unstable, despite initial resuscitative measures. Hope for stabilization is contingent upon the following specialty care and/or resources not available at Hartford Hospital:

________________________________________

Type of specialty care and/or resources required

-or-

___ Patient is unstable but refuses further care at Hartford Hospital, despite the offer to provide such care and an explanation of medical condition and the risks of transfer.

Mode of Transfer, as warranted by patient’s condition
The patient is being transferred by qualified personnel, with transportation equipment available as warranted by the patient’s condition, including use of necessary and medically appropriate life support measures.

Transported by

___ Ambulance _____________________________
   Company

___ Helicopter _____________________________
   Flight Program

___ Private vehicle

___ Other _________________________________

Highest level provider available en route

___ MD/DO

___ RN

___ FN

___ Non-medical personnel

___ EMT-A

___ EMT-1

___ EMT-P

Receiving Facility
Transfer will be to __________________________, which has available space and has personnel qualified to treat the patient’s condition, as acknowledged by ___________________________ Date ___________ Time ____________

Name Title

The patient has been accepted in transfer by __________________________ Date ___________ Time ____________

Name Title

who has stated that appropriate medical treatment will be provided.
PROVIDER’S CERTIFICATION OF TRANSFER PROCEDURES
(Complete both sides)

Medical Records to Accompany Patient
Copies of the medical records of the examination and treatment of the patient have been made, to accompany the patient in transfer to the receiving facility.

___________________________________________________________________________

Initials for verification

___________________________________________________________________________

Risks and Benefits of Transfer Explained to Patient
I have examined the patient and have explained to the patient or legally responsible individual the medical benefits and risks of being transferred. The risks and benefits may be summarized as follows:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

______________________________ Date _________________ Time _________________
Provider’s signature

Certification That Benefits of Transfer Outweigh Risks
(Do Not Sign if unstable patient refuses stabilization offered at Hartford Hospital.)
I certify that to the best of my belief, the medical benefits reasonably to be expected from receiving appropriate treatment at the facility to which the patient is being transferred outweigh possible risks, if any, to the patient’s medical condition that might reasonably be expected to result from the transfer.

______________________________ Date _________________ Time _________________
Provider’s signature

______________________________ Date _________________ Time _________________
Physician’s countersignature
(If Provider above is not a physician)
REFUSAL FOR FURTHER MEDICAL EXAMINATION AND TREATMENT AND OR CONSENT TO TRANSFER AS REQUESTED BY PATIENT

I have been informed of my rights regarding further examination, treatment, and transfer. I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical professional and/or my private physician, who has recommended and offered to me further medical examination and treatment at Hartford Hospital. The potential benefits of such further examination and treatment, and the potential risks associated with transfer to another facility, have also been explained to me, and I fully understand. Having considered these facts and recommendations, I refuse consent for further examination and treatment at Hartford Hospital, and I request transfer to:

________________________________________________________

Name of receiving facility

I have been informed of the following reasonably foreseeable risks that include, but are not limited to:

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

Patient or legal authorized representative reason(s) for requesting transfer:

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

Signature of patient or legally authorized representative

Date ________________ Time ________________

Witness

Date ________________ Time ________________