Hartford Hospital
A Hartford HealthCare Partner

6816

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:

_____ Name of individual accepting transfer at _____ 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 _____ Name of receiving facility by _____ Name of individual accepting transfer.

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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 ___ EMT-A

___ RN ___ EMT-1

___ FN ___ EMT-P

___ Non-medical personnel

Receiving Facility

Transfer will be to _____ , which has available space and has personnel qualified to treat
Name of receiving facility

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.

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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)

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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 _____