Oregon Health & Science University
Hospitals and Clinics
3181 SW Sam Jackson Park Road
Portland, OR 97239 (503) 494-7551

EMERGENCY SERVICES HOSPITAL TRANSFER

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Stamp Patient Card Here

1. PATIENT CONDITION ☐ Stable for transfer to another facility ☐ Unstable

2. REASON FOR TRANSFER **I request / consent to be transferred to the receiving facility indicated for the following reason(s):**

___ Physician Request – I require specialty services not currently available at OHSU.
___ I want to go to another hospital.
___ Continuity of care for services to be provided at the receiving facility.

3. I have reviewed the information provided and request / consent to be transferred to the receiving facility. I have been informed of the risks, benefits, and reasons for transfer. I have also been informed that the transferring hospital is required to stabilize my emergency medical condition unless I request to be transferred to another facility or unless the physician certifies that the medical benefits reasonably expected at the receiving facility outweigh the risks of transfer.

_____ _____
Signature of Patient ***or*** Witness Date Time
Person Acting ***or*** Legally Responsible for Patient

_____
Print Name & Relationship for Patient (if Legally Responsible)

4. TRANSFER REFUSED: I have been advised by Dr. _____ to accept transfer to: _____ for medical reasons and I hereby refuse transfer.

_____ _____
Signature of Patient ***or*** Witness Date Time
Person Acting ***or*** Legally Responsible for Patient

_____
Print Name & Relationship to Patient (if Legally Responsible)

5. RISKS OF TRANSFER
___ Medical condition could worsen during transport, possibly resulting in disability or death.
___ Patient will not obtain recommended follow-up care.
___ Transportation risks.

6. BENEFITS OF TRANSFER
___ Specialty services not available at OHSU.
___ Capacity (beds, equipment, staff) not currently available at OHSU
___ Continuity of Care / Managed Care Plan / Pt Request / Pt Preference.

7. RECEIVING FACILITY
Facility Name:_____
Facility Representative:_____Time:_____
(Receiving facility staff person confirming available space and qualified personnel for treatment, and accepting personnel if authorized.)

Accepting Physician Name:_____Time:_____
(Physician at the receiving facility accepting the patient in transfer)

Report called to (Name & Title):_____ Time:_____

8. DOCUMENTATION

Copies of the following have been provided for the receiving facility:
___ Medical Records
___ Lab Results
___ Radiology Results / Films

9. TRANSPORTATION ☐ ALS ☐ BLS Agency Name:_____ ☐ POV

10. FACULTY PHYSICIAN CERTIFICATION OF TRANSFER **(To be completed by Faculty Physician at time of transfer)**.

I confirm the patient's condition and the benefits / risks of transfer as stated above. Based on the information available at this time. I have determined that the medical benefits reasonably expected from the provision of appropriate medical care at the receiving facility outweigh any potential risks to the patient, and in the care of labor, to the unborn child.

_____ _____
Certifying Faculty Signature Date

_____
Print Faculty Name

ORIGINAL – SEND TO MEDICAL RECORDS **COPY – SEND WITH PATIENT DURING TRANSFER**

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