



**CONSENT FOR TRANSPORTATION  
AND TREATMENT**

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

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Stamp Patient Card Here

Patient: \_\_\_\_\_

If minor, guardian's name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

1. Condition

I understand that Dr. \_\_\_\_\_ at \_\_\_\_\_ Hospital recommends immediate transfer to the Oregon Health & Science University Hospital, or \_\_\_\_\_ for emergency treatment or care. The diagnosis is: \_\_\_\_\_

The nature of this diagnosis has been explained to me, and I understand the potential risks of this condition with and/or without transfer.

2. Risks of Transportation

I understand that the risks of transporting include the general risks associated with all transportation, such as possible failure of medical equipment, aircraft, or vehicle, traffic hazards, adverse weather conditions, pilot or driver error, interruption of medical treatment during transportation, or consequences of actions of persons outside the control of transport personnel. There are risks associated with all transports which include the possible worsening of the condition during transport or inability to fully treat emergent, unforeseen problems due to the limitations of available equipment and facilities.

3. Authorization of Transportation and Emergency Treatment

Understanding the condition, and the risks associated with transportation, as outlined above, I accept the opinion of my physician that the condition justifies transportation and emergency treatment or me. Therefore, I authorize transportation by surface and/or air, and I further authorize the doctors and/or nurses of the transport staff and the doctors of the referral hospital to assume full care and to perform any emergency medical or surgical procedures which are necessary in their professional judgement.

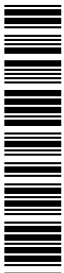
I have read this form completely and understand it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date and Time



CO1436