1210 N. Washington | PO Box 389
Plainville, KS | (785) 434–4553
http://www.rookscountyhealthcenter.com

# EMTALA PLUS FORM – KANSAS

### Patient Arrival / Departure

**Patient's Arrival Date and Time at Sending Facility**

Arrival Date: ______ Time: ______ 24 hour time

**Patient's Departure Date and Time at Sending Facility**

Departure Date: ______ Time: ______ 24 hour time

**Destination Room, Unit and/or Procedural Area (i.e. cath lab) if known:**______

☐ **Emergency Room** ☐ **Other:**______

### Patient Condition

☐ The patient has been provided medical treatment to minimize the risk to the individuals health (and in the case of pregnancy, the unborn child) within the sending hospital's capability to minimize the risks of the transfer (Unstable)

☐ No material deterioration of the patient's condition is likely to result from the transfer (if the patient is pregnant, delivery is not imminent and there is adequate time to effect a safe transfer before delivery (Stable)

### Reason for Transfer of Unstable Patient

☐ Higher level of care is required/sending hospital lacks capacity (complete Physician / QMP certification below. Obtain patient consent to transfer, if possible).

☐ Patient / responsible person's request for transfer against medical advice (Complete AMA form)

### Physician or Qualified Medical Person (QMP) Certification

I certify that based upon the information available at the time of the transfer the medical benefits reasonably expected from transfer and treatment at the receiving facility, outweigh the increased risk, if any, to the patient or in the case of a pregnancy, including the unborn child.

Signature of Physician or QMP (in consultation with Physician):

______

Print Name: ______

Date: ______ Time: ______ 24 hour time

Countersignature of Physician that QMP certified (Obtaining counter signature within 72 hours is best practice):

______

Print Name: ______

Date: ______ Time: ______ 24 hour time

### Receiving Facility Acceptance of Transfer

Receiving facility that has agreed to accept the transfer, has available space, and has qualified personnel for the treatment of this patient.

Print name of physician accepting transfer:

______

Date: ______ Time: ______ 24 hour time

Print name of receiving facility:

______

Print City: ______ Print State ______

### Sending Nurse Information and Nurse to Nurse Report

**Transferring nurse signature:**

______

Print name:______

Date/Time:______

**Print name of nurse receiving report:**

______ **RM#** ______

### Transfer Method Determined by Physician

Qualified personnel with appropriate medical equipment who will be able to provide necessary and appropriate life support measures will transfer the patient

Transfer Initiated: Date: ______ Time: ______ 24 hour time

☐ BLS agency (ground) ☐ ALS staff (ground)

☐ Additional staff: ______

☐ Helicopter ☐ Fixed Wing ☐ Other Agency (air): ______

☐ Other: ______

### Name of company transporting and contact information

Transporting company name: ______

Contact Number: ______

### Patient Consent or Refusal

I understand that all trasfers have risks, my condition may worsen, and a vehicular accident or equipment failure may occur. If I am pregnant and in labor, I understand I may progress to delivery during transfer.

**Additional risks are as follows:**

______

______

I have been offered and received a medical screening and treatment by a physician or qualified medical person, and have been informed of and understand the reasons for my transfer. I hereby:

☐ Consent to transfer

☐ Refuse transfer (Complete AMA form).

☐ Refuse recommended mode of transportation, and will provide my own transportation to the receiving facility (Complete AMA form)

☐ Refuse examination or treatment to stabilize my condition, and/or request transfer to another facility (Complete AMA form).

Patient / Responsible Person Signature:

______

Print name/ relationship of responsible person:

______

Cell Phone Number: ______

Date: ______ Time: ______ *24 hour time*

**Witnesses:** one witness if patient/responsible person signs, and two witnesses if phone consent by responsible person is provided

1st Witness signature: ______

Witness print name: ______

Date: ______ Time: ______ 24 hour time

2nd Witness signature: ______

Witness print name: ______

Date: ______ Time: ______ 24 hour time

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## Last Known Normal (if applicable)

Identify the date / time of the patient's last known normal: Date/Time:__________________ *24 hour time*
Individual present at onset or witnessed event:
Print name:________________________________________Cell Phone: ______________________________

## Resuscitation Status at Sending Hospital

NOT AN OFFICIAL RECORD, MUST CONFIRM CURRENT STATUS UPON ARRIVAL

☐ Full Code ☐ Do Not Resuscitate (DNR) ☐ Other: ______________________________________________

## Patient Clinical Indicators

**Vital Signs at time of transfer (within 5 minutes of departure)**

T________ P________ R________ B/P______/______ SpO2:_________ Weight (in kg):___________

**IV Information or** ☐ **does not apply**

Site:_____________ Size:_____________ Time:_____________*24 hour time* Date:_______________

## Records sent with patient (or faxed within 60 minutes):

☐ Radiographs ☐ Cloud ☐ Disc

☐ Current medical record (i.e. face sheet, ED key documentation, H&P, lab results, nursing shift report, progress notes, transition of care document, MAR, home medication list)

☐ EKG ☐ EMS Run Sheet

☐ Pending test results available more than 60 minutes after discharge and plan to communicate results

Print test description: ____________________________________________________________________

Results will be sent by: ☐ Fax ☐ Phone ☐ Other:____________________________________________

## Medications Given at Sending Facility

| Medications | Dose | Time Given (24 hour time) | Medications | Dose | Time Given (24 hour time) |
|---|---|---|---|---|---|
| Analgesic | | | Lipitor | | |
| Anticoagulant | | | Metoprolol po/iv (circle one) | | |
| Antihypertensives | | | NTG SL/IV Drip (circle one) | | |
| ASA | | | Oxygen | | |
| Heparin Bolus | | | TNK Bolus MI dose | | |
| Heparin Drip | | | TPA Bolus stroke / MI dose (circle one) | | |
| IVF(s) | | | TPA Drip | | |
| Other | | | Other | | |
| Other | | | Other | | |

! **Allergies (write in below) OR** ☐ **NKDA (no known drug allergies)**

______________________________________________________________________________

! **Valuables / Belongings**

☐ Given to responsible person below ☐ Sent with patient (list items):_______________________

Print Name: ___________________________ List valuables: ___________________________________

| Glasgow Coma Score: | Admit | Discharge |
|---|---|---|
| **Eye(s) Opening** | ________ | ________ |
| Spontaneous | 4 | 4 |
| To speech | 3 | 3 |
| To pain | 2 | 2 |
| No response | 1 | 1 |
| **Verbal Response** | | |
| Oriented to time, place, person | 5 | 5 |
| Confused / Disoriented | 4 | 4 |
| Inappropriate words | 3 | 3 |
| Incomprehensible sounds | 2 | 2 |
| No response | 1 | 1 |
| **Best Motor Response** | | |
| Obeys commands | 6 | 6 |
| Moves to localized pain | 5 | 5 |
| Flexion withdraws from pain | 4 | 4 |
| Abnormal flexion | 3 | 3 |
| Abnormal extension | 2 | 2 |
| No response | 1 | 1 |

**Best Response 15**
**Comatose patient 8 or less**
**Totally unresponsive 3**

| NIHSS Score | | Admit | Discharge |
|---|---|---|---|
| NIHSS Score | Stroke Severity | _____ | _____ |
| 0 | No Stroke | | |
| 0 – 4 | Minor Stroke | | |
| 5 – 9 | Moderate Stroke | | |
| *10 – 20 | Moderate to Severe Stroke | | |
| 21 – 42 | Severely Critical Stroke | | |
| * > 10 | Transfer to Interventional Center | | |

| Important! Contact Information for Follow–up Requested on this Patient | Important Contact Information for this Patient | | Patient Progress Note Communication #2 Contacts | Patient Summary of Care Communication #3 Contacts |
|---|---|---|---|---|
| Follow–up must be sent via secure email to a secure inbox, or sent to a secure fax | Recipient #1 Sending Hospital | Print Name | Jaime Gosselin | |
| | | Secure e–mail address | | |
| | | Secure fax number | 785–688–4441 | |
| | Recipient #2 Sending Hospital | Print Name | | |
| | | Secure e–mail address | | |
| | | Secure fax number | | |
| **Please print legibly or attach EMTALA Plus Contact Form** | Recipient #2 Sending Hospital | Print Name | | |
| | | Secure e–mail address | | |
| | | Secure fax number | | |