EMTALA Transfer Record

Medicine Lodge Memorial Hospital (MLMH)
710 North Walnut
Medicine Lodge, KS 67104
Tel: 620-886-3771 Fax: 620-930-3787

Certificate of Transfer:
This is to certify that an appropriate medical screening examination within the capability of the hospital / emergency department was performed at Medicine Lodge Memorial Hospital on ________________, 20_______ at ________(time) and necessary stabilizing treatment has been performed.

Patient Condition:
Based upon my examination of the patient and the information available at the time of examination, I certify that the benefits of transfer outweigh the risks.

- Emergent condition is STABILIZED; no reasonable likelihood of deterioration from or during transfer.
- Emergency condition persists despite best efforts / UNSTABLE. I certify that the benefits of transfer outweigh the risks.
- Patient is pregnant with contractions and / or bleeding / UNSTABLE.

Reason for Transfer:
- Specialty services and/or equipment are not available at MLMH.
- Patient/ legal guardian requests transfer. Services are provided at MLMH & offered but patient/guardian desires transfer.
- Patient requests transfer because insurance plan does not list MLMH as a covered facility.

Medical Benefits of Transfer:
- Receiving facility has resources, personnel, and equipment to provide higher level of care.
- Other:______________________________________

Risks of Transfer:
- Death
- Bleeding
- Harm to self /others
- Delivery/Fetal Distress
- MI/Cardiac decompensation / arrest
- Pulmonary decompensation/ arrest
- Decreased level of consciousness
- Vehicular accident/transport hazards
- Extension of Stroke / Paralysis
- Other____________________

Discharge Disposition / Receiving Facility:
- Kansas Heart Hospital
- Via Christi / St Francis
- Wesley Medical Center
- Hutchinson Regional Medical Center
- Pratt Regional Medical Center
- Other:____________________

Provider-to-Provider Approval of Transfer:
The Practitioner has spoken with the Physician and has agreed to accept the patient and provide appropriate medical services.

Dr. _________________________ accepted transfer at: _______________(time)

Transferring & Reporting Practitioners Signature: ________________________ Date:_________ Time:_______

Patient Consent:
The risks and benefits of transfer have been explained to me. I understand the consequences associated with the transfer, therefore:

- I Consent to transfer
- I Refuse ambulance transfer. I will provide my own transportation to the above named receiving facility.
- I DO NOT CONSENT to transfer (complete AMA form)

Patient Signature ________________________ Signature of responsible person on behalf of patient ________________________

Witness ________________________ Witness ________________________ Relationship of responsible person ________________________

Date:_________________________ Time:_________________________
Mode of Transport:
*Qualified personnel with appropriate medical equipment that will be able to use all necessary and appropriate life support measures will transfer the patient.
- [ ] Ground Ambulance
- [ ] Helicopter
- [ ] Fixed Wing
- [ ] Private Vehicle
- [ ] Police Transport

Transport Provider:
- [ ] BCEMS
- [ ] Life Save
- [ ] Eagle Med
- [ ] Police

Transport Details:
- Time Contacted:  
- Time Arrived:  
- Report given  
- Time Departed:  

Additional Transport Staff:
- [ ] MD / DO
- [ ] APRN / PAC
- [ ] RN
- [ ] Paramedic
- [ ] Police
- [ ] N/A

Valuables / Belongings:
- [ ] Given to the Family
- [ ] Sent with the patient
- [ ] N/A

Healthcare Facility to Healthcare Facility Nurse Contact:
The receiving facility has agreed to accept the transfer, provide appropriate medical treatment and has available space and qualified personnel for the treatment of this patient.

Name of person accepting transfer: __________________________ at ________(time). Bed Assignment: ________ Nurse Initial: ________

RN/LPN Name: __________________________ called report to: __________________________ at ________(time)


Transfer Records: (Send with Patient or Fax within 60 minutes)
- Face Sheet Sent: ________ Fax: ________ N/A ________
- Insurance Info Sent: ________ Fax: ________ N/A ________
- Allergies / Reactions Sent: ________ Fax: ________ N/A ________
- Home Med List Sent: ________ Fax: ________ N/A ________
- Provider ED Note Sent: ________ Fax: ________ N/A ________
- MAR / Meds given Sent: ________ Fax: ________ N/A ________
- Lab done & Results Sent: ________ Fax: ________ N/A ________
- EKG done & Results Sent: ________ Fax: ________ N/A ________
- X-Ray done & CD Sent: ________ Fax: ________ N/A ________
- CT done & CD Sent: ________ Fax: ________ N/A ________
- Other Tests Done Sent: ________ Fax: ________ N/A ________
- Other Test Results Sent: ________ Fax: ________ N/A ________

Date: ___________ Time Sent: ___________ Staff Initials: ________

Date: ___________ Time Faxed: ___________ Staff Initials: ________

Nursing Documentation:

- EHR Printed Report / Nurses Notes Sent: ________ Fax: ________ N/A ________
- Oral Restrictions / NPO since: ________ Sent: ________ Fax: ________ N/A ________
- Catheters / IV Sent: ________ Fax: ________ N/A ________
- Immobilizations (c-collar, spine, splint) Sent: ________ Fax: ________ N/A ________
- Respiratory Support (Oxygen, BVM, BiPap) Sent: ________ Fax: ________ N/A ________
- Impairments: (Hearing aide, Glasses) Sent: ________ Fax: ________ N/A ________
- Other: __________________________ Sent: ________ Fax: ________ N/A ________
- EMTALA form (copy) Sent: ________ Fax: ________ N/A ________

Date: ___________ Time Sent: ___________ Staff Initials: ________

Date: ___________ Time Faxed: ___________ Staff Initials: ________

Emergency Contact Information:

Name: __________________________ Relationship: ________ Phone #: ________

Name: __________________________ Relationship: ________ Phone #: ________

EMTALA Transfer Record December 2019