THE UNIVERSITY OF NEW MEXICO • HEALTH SCIENCES CENTER
UNM HOSPITALS

Clinic Transfer – To Inpatient (Facility outside the HSC)

Based on the reasonable risks and benefits to the patient and based on the information available at the time of the patient's transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks, if any, to the patient's medical conditions (including in the case of a pregnant woman, the rights to the unborn child (ren)) from affecting the transfer.

REASON FOR TRANSFER: ____ No Bed Available ____ Patient Request ____ Other-Document Reason

RISKS AND BENEFITS OF TRANSFER:
Comments _____
_____

PATIENT STABILIZED (choose one)
___ The patient has been stabilized such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during the transfer (A patient in active labor has been stabilized if she has delivered, including the placenta.)
___ Patient is in active labor and, based on information available at the time of her examination, the medical benefits of transfer outweigh the risks of transfer AND both have been explained to the patient.
___ Patient's condition has NOT been stabilized because ___ Patient refused ____Other reason - Specify
_____

TRANSFER REQUIREMENTS
Note: The patient ***may not be transferred unless all*** the following requirements are met:
___ The receiving facility has available space and qualified personnel for the treatment of the patient
___ The receiving facility has agreed to accept transfer and to provide appropriate medical treatment.
1. Name of receiving facility _____
2. Name of the individual accepting transfer _____

___ The receiving facility will be provided with appropriate medical records of the examination and the treatment of the patient.
___ The patient will be transferred by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures.

MEANS OF TRANSPORT: ___ Private Car ___ Ambulance ___ ACLS ___ Other-Specify_____

PHYSICIAN CERTIFICATION
I certify that I have answered the above questions based upon the information available to me at the time of the patient's transfer. I further certify that I have made the appropriate disclosures as indicated on this form.

Physician authorizing transfer _____ _____
Name (Please Print) **Physician Signature**

TRANSFER CONSENT
I acknowledge that my medical condition has been evaluated and explained to me by _____ (name of physician) who has recommended that I be transferred as noted above.
Or, I request transfer _____ (signature)

The potential benefits of such transfer, the potential risks associated with such transfer and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred.
SIGNED _____ **WITNESSED BY** _____
(Signature of Patient or Legally Responsible Individual signing on Patient's Behalf) (Other than Member of the Family)

Relationship to Patient _____ _____ _____ AM - PM
Date Time

PATIENT STICKER