EMTALA Talking Points for Patients Who Are Inpatients and Transferring to Another Hospital

- The movement of a patient from one hospital to another is a “transfer” (ie: NHRMC to Cherry Hospital, NHRMC to Walter B Jones)

- There are federal transfer requirements. Although EMTALA does not apply to admitted patients (inpatients), we use the EMTALA transfer form to document these requirements (Intrafacility EMTALA Transfer Record VL-002 (3/07 v.2.). The receiving hospital expects to see this form!

- One you are aware that the patient is moving to another hospital and/or receive the transfer order, notify the Regional Transfer Center at 910-815-5155.

- Prior to any transferred patient leaving, the transfer paperwork must be checked (no exceptions) regardless of the time of day and as soon as possible, call the Administrative Operations Officer pager at 910-254-2337 and let them know that the transfer paperwork needs to be checked.

EMTALA Documentation Requirements: (Intrafacility EMTALA Transfer Record)
- Diagnosis
- Medical Condition
- Reason for transfer-If the reason for transfer if a service we do not provide here note that, for example “burns” or “substance abuse”.
- Risks and benefits-both must be completed (III on form)
- Mode of transportation
- There must be a receiving physician-write the physician’s name (V on form)
- Report must be given to receiving hospital-write the name of the person who received your report
- Transferring (NHRMC) physician signature (V on form)-The physician must sign the form at the time of transfer to include date and time (within 30 minutes of transfer). The signature represents that the patient at the time of transfer is stable for transfer, that the risks and benefits were explained to the patient and that there is a receiving physician.
- Nursing (VI on form)-Pertinent parts of the medical record must go with the patient. Example: H&P, Discharge summary, IVC papers (if applicable), pertinent labs and radiology reports.
- Patient consent
- At the time of transfer, vital signs must be taken and documented in section VI (Note: If vitals are not WNL for that patient, physician must be notified prior to transfer unless other applicable orders for notification were written).

Contact Pat Wheeler via e-mail or at 910-815-5334 if you have any questions.
**Physician Certification Statement for Medical Transport**
*Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)*

### SECTION I - GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Patient's Name: ______________________________________</th>
<th>Return to prior arrangement: _____________</th>
<th>New Placement:_______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Transport Date: ___________________</td>
<td>Repetitive Transport Expiration Date (Max 60 Days From Date Signed): _______________</td>
<td></td>
</tr>
<tr>
<td>Origin: _____________________________________________________</td>
<td>Destination: ___________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be “bed confined” the patient must be: (1) **unable** to get up from bed without assistance; AND (2) **unable** to ambulate; AND (3) **unable** to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

1) Is this patient “bed confined” as defined above?  
☐ Yes  ☐ No

2) Describe the Medical CONDITION of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:
________________________________________________________________________________________________________________

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)  
☐ Yes  ☐ No

4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply*:  
*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

- [ ] Advanced airway maintenance required
- [ ] Confused, combative, lethargic, or comatose
- [ ] Danger to self/others or flight risk
- [ ] DVT requires elevation of a lower extremity
- [ ] IV meds/liquids required
- [ ] Moderate/severe pain on movement
- [ ] Morbid obesity requires additional personnel/equipment to safely handle patient
- [ ] Third party assistance required to apply, administer or regulate or adjust oxygen en route (RARE)
- [ ] Other:__________________________________________
- [ ] Cardiac/hemodynamic monitoring required
- [ ] Contractures
- [ ] Decubitus ulcers on buttocks, Grade II or greater
- [ ] Isolation/special handling required
- [ ] Maximum assistance required for transfers (2 or more)
- [ ] Non-healed fractures (pelvis, spine, hip)
- [ ] Orthopedic device requiring special handling during transport (backboard, halo, use of pins in traction, etc.)
- [ ] Unable to maintain erect sitting position in a chair for time needed for transport

### SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

MD*/Healthcare Professional Signature ________________________ ☐ MD ☐ PA ☐ NP ☐ RN** ☐ CNS** (check appropriate title)
Printed name__________________________ Date _________________ Time _________________

*Form must be signed only by patient's attending physician for scheduled, repetitive transports.

**RN or CNS signature must be accompanied by a physician order specifying ambulance transport.

FAX completed form to 815-5005. Call 815-5155 to verify receipt of FAX.
A completed, signed PCS must be available to Regional Communications (Dispatch) before an ambulance is dispatched.