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.
# STEMI Handoff Sheet

## Zone 1

To be completed by Referral Hospital:

<table>
<thead>
<tr>
<th>Referral Hospital</th>
<th>Cape Fear Hospital</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

**Symptom Onset**

**Pertinent Medical History:**
- ☐ Previous Stent
- ☐ CABG
- Other __________

**Allergies**

**Patient Weight**

Is the patient taking any of the following:
- ☐ Warfarin (Coumadin)
- ☐ Prasugrel (Effient)
- ☐ Dabigatran (Pradaxa)
- ☐ Ticagrelor (Brilanta)
- ☐ Rivaroxaban (Xarelto)
- ☐ Clopidogrel (Plavix)
- ☐ Apixaban (Eliquis)

**Medications Administered:**
- □ ASA 325mg PO
- □ Heparin Bolus 60 IU/Kg ____________ IU Administered
- □ Ticagrelor (Brilanta) 180 mg PO ____________ mg Administered
- □ NTG PRN SL or Paste
  - Avoid IV NTG or IV Heparin

**Additional Medications Administered**

**Vital Signs:**
- BP _________   HR _________   RR _________   SaO2 _________

Prepare patient for rapid transfer:
- • Remove clothing, place patient in gown
- • Prep patient and family for rapid handoff to transfer staff
- • Have paperwork ready for transfer:
  1. Copy of diagnostic EKG
  2. EMTALA & PCS (AirLink)
  3. STEMI Handoff Sheet
- • Fax any additional paperwork to Regional Communications: 910-815-5005

**Referral Hospital Signature**  _____________________________________

To be completed by Interfacility Transfer Agency:

<table>
<thead>
<tr>
<th>Transfer Agency</th>
<th>____________________________</th>
</tr>
</thead>
</table>

**Additional Medications Administered**

**Additional Interventions Performed**

**Additional Vital Information**

**Vital Signs:**
- BP _________   HR _________   RR _________   SaO2 _________

**Referral Agency Signature**  _____________________________________

*updated March 2013*
Physician Certification Statement for Medical Transport

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)

SECTION I - GENERAL INFORMATION

Patient's Name: ______________________________________
Return to prior arrangement: _____________
New Placement:_______________

Initial Transport Date: ___________________
Repetitive Transport Expiration Date (Max 60 Days From Date Signed): ____________________

Origin: _____________________________________________________
Destination: ___________________________________________________

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 TRANSPORTATION 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.

THIS FORM PART OF PERMANENT MEDICAL RECORD

VL-007 (11/09 v.9)

*0407*
Please Include 12-Lead Here
Please Include Patient Chart Here