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

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

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.
INTERFACILITY EMTALA TRANSFER RECORD

Emergency Medical Condition (EMC) Identified: (Mark appropriate box(es), then go to Section II)

I. MEDICAL CONDITION: Diagnosis

☐ No Emergency Medical Condition Identified: This patient has been examined and an EMC has not been identified.

☐ Patient Stable - The patient has been examined and any medical condition stabilized such that, with reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

☐ Patient Unstable - The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

II. REASON FOR TRANSFER:

☐ Medically Indicated

☐ Patient Requested

☐ On-call physician refused or failed to respond within a reasonable period of time.

Physician Name

Address

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits:

☐ Obtain level of care / service NA at this facility.

☐ Service

☐ benefits outweigh risks of transfer

Medical Risks:

☐ Deterioration of condition en route

☐ Worsening of condition or death if you stay here.

There is always risk of traffic delay/accident resulting in condition deterioration.

IV. Mode/Support/Treatment During Transfer as Determined by Physician - (Complete Applicable Items):

Mode of transportation for transfer:

☐ BLS

☐ Helicopter

☐ Neonatal Unit

☐ Private Car

☐ Other

Agency

Name/Title accompany hospital employee

Support/Treatment during transfer:

☐ Cardiac Monitor

☐ Oxygen - (Leters)

☐ Pulse Oximeter

☐ IV Pump

☐ IV Fluid

Rate

☐ Restraints - Type

☐ Other

☐ None

Radio on-line medical oversight (If necessary):

☐ Transfer Hospital

☐ Destination Hospital

☐ Other

V. Receiving Facility and Individual:

The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility / Person accepting transfer

Time

Receiving MD

Transferring Physician Signature

Per Dr. RN/ Qualified Medical Personnel

Date/Time

VI. ACCOMPANYING DOCUMENTATION - sent via:

☐ Patient/Responsible Party

☐ Fax

☐ Transporter

☐ Copy of Pertinent Medical Record

☐ Lab / EKG / X-Ray

☐ Copy of Transfer Form

☐ Court Order

☐ Advance Directive

☐ Other

Report given (Person / title)

Date

Nurse Signature

Unit

Time of Transfer

Date

Pulse

R

BP

Time

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUESTED" TRANSFER:

☐ I hereby CONSENT TO TRANSFER to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

☐ I hereby REQUEST TRANSFER to ______________________________. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.

The reason I request transfer is

Signature of ☐ Patient ☐ Responsible Person

Relationship

Witness

Witness

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

*0401*

ORIGINAL - MEDICAL RECORD

YELLOW - TRANSPORT

VL-002 (3/07 v.2)
Please Include 12-Lead Here If Available
Please Include Patient Chart Here