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*:

☐ 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 personnel/equipment to safely handle patient ☐ Orthopedic device requiring special handling during transport (backboard, halo, use of pins in traction, etc.)
☐ Third party assistance required to apply, administer or regulate or adjust oxygen en route (RARE) ☐ Unable to maintain erect sitting position in a chair for 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

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>No Emergency Medical Condition Identified: This patient has been examined and an EMC has not been identified.</td>
</tr>
<tr>
<td>☐</td>
<td>Patient Stable - The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.</td>
</tr>
<tr>
<td>☐</td>
<td>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 have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, 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.</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Medical Benefits</th>
<th>Medical Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Obtain level of care / service NA at this facility.</td>
</tr>
<tr>
<td>☐</td>
<td>Service</td>
</tr>
<tr>
<td>☐</td>
<td>benefits outweigh risks of transfer</td>
</tr>
<tr>
<td>☐</td>
<td>Deterioration of condition en route</td>
</tr>
<tr>
<td>☐</td>
<td>Worsening of condition or death if you stay here.</td>
</tr>
<tr>
<td>☐</td>
<td>There is always risk of traffic delay/accident resulting in condition deterioration.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Mode of transportation for transfer:</th>
<th>☐ BLS ☐ Helicopter ☐ Neonatal Unit ☐ Private Car ☐ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Name/Title accompany hospital employee</td>
</tr>
<tr>
<td>Support/Treatment during transfer:</td>
<td>☐ Cardiac Monitor ☐ Oxygen - (Liters) ☐ Pulse Oximeter ☐ IV Pump</td>
</tr>
<tr>
<td>☐ IV Fluid</td>
<td>Rate</td>
</tr>
<tr>
<td>☐ Other</td>
<td>Type</td>
</tr>
</tbody>
</table>

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
Agency
Name
Address

Receiving MD
Transferring Physician Signature

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)

<table>
<thead>
<tr>
<th>Time of Transfer</th>
<th>Date</th>
<th>Nurse Signature</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs Just Prior to Transfer</td>
<td>Pulse</td>
<td>R</td>
<td>BP</td>
</tr>
</tbody>
</table>

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