JERSEY SHORE

Hospital Transfer Orders

Date	Time

Addressograph

1. **Transfer Patient to:** [ ] Susquehanna Health [ ] Geisinger Medical Center [ ] Other: _____
2. **Accepted by:** Dr _____
3. **Reason for transfer:** _____
4. **Mode of Transfer:** [ ] BLS
   [ ] ACLS: [ ] Drips [ ] Ventilation [ ] Cardiac monitor [ ] Equipment
   [ ] Life Flight/Helicopter: [ ] Drips [ ] Ventilation [ ] Cardiac monitor [ ] Equipment
   [ ] Other: _____
5. **Condition:** [ ] Stable [ ] Unstable
6. **Obtain consent to release following records:**
   [ ] History & Physical [ ] X-rays [ ] Radiology disc-call X-ray
   [ ] Labs [ ] Cardiopulmonary tests [ ] Medication Administration Records
   [ ] Progress notes [ ] Other _____
7. **Physician must complete and sign:**
   - PHYSICIAN CERTIFICATION FOR TRANSFER
   - PHYSICIAN MEDICAL NECESSITY CERTIFICATION
   - ORDER SHEET
8. **Patient (or responsible party) must sign:**
   - PHYSICIAN CERTIFICATION FOR TRANSFER in the Patient Consent for Transfer section
   - AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
   - PAYMENT OF TRANSFER CHARGES
9. **Nurse must complete & sign:**

- PATIENT TRANSFER FLOWSHEET INTERHOSPITAL TRANSFER. Include name of nurse receiving report, time of report, pertinent information, vital signs and condition of patient at time of transfer
- Check box and initial bottom of AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION **([ ] ALL REQUESTED ITEMS SENT _____)**
  INITIALS
- Vital signs just prior to transfer on flow sheet
- Copy of updated Home Medication list
- Keep white copies of carbon sheets
- Give transfer packet to EMS crew
- Remove hospital equipment from patient
- Notify family of plans and departure
- Complete PATIENT TRANSFER CHECK LIST and **hold patient if any items are not completed**

_____
Physician Signature

JERSEY SHORE

PHYSICIAN CERTIFICATION FOR TRANSFER

Addressograph

The undersigned physician hereby certifies that based on the information available at this time, the transfer of _____ to _____ is medically necessary
(Patient Name) (Receiving Hospital)

and appropriate based upon bed availability or provision of services, and outweighs the increased risks associated with this transfer of the patient, or, in the case of a patient in labor, the risk to the unborn child. The risks and benefits have been explained to the patient and/ or family.

_____ _____
(Date/Time) (Physician Signature)

Transfer is accepted by: _____ on _____
(Name of Receiving Physician) (Date/Time)

Patient Consent for Transfer

I agree to be transferred to _____, which has accepted me for transfer.

Dr _____has explained to me the transfer is needed or advisable because:

_____

_____

I also consent to the release of all medical records necessary for the continuity of care.

_____ _____
(Date/Time) (Signature of Patient)

_____ _____
(Date/Time) (Signature of Responsible Person / Relationship)

_____ _____
(Date/Time) (Signature of Witness)

PHYSICIAN'S MEDICAL NECESSITY CERTIFICATION

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s)
(This applies to Repetitive Transports and/or One-Time Transports)

PATIENT'S NAME		HEALTH INSURANCE CLAIM NUMBER (HIC)
TRANSPORT DATE	TRANSPORTED FROM	TRANSPORTED TO

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when patient condition is such that transportation by any other means is contraindicated. Please complete the questions below in order for the ambulance claim to be evaluated under Medicare coverage criteria.

The Health Care Financing Administration has defined "bed confinement" as (all three bullets must be met):

The patient is:

- unable to get up from bed without assistance
- unable to ambulate; and
- unable to sit in a chair or wheelchair

1) Is the patient bed-confined as defined by the above definition? [ ] Yes [ ] No

2) If No, please check the appropriate medical conditions listed below.

This patient:

[ ] requires restraints to prevent harm and/or injury

[ ] requires cardiac monitoring

[ ] requires continuous oxygen monitoring by trained staff
Note: patients who are generally mobile with portable oxygen would not require non-emergency ambulance transportation based solely on the need for oxygen.

[ ] had to remain immobile because of a fracture that had not been set or the possibility of a fracture (i.e. hip fracture

[ ] is ventilator dependent

[ ] requires continuous IV therapy

[ ] other, please specify, _____

_____

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THIRD PARTY PAYERS SUCH AS THE MEDICARE PROGRAM.. I UNERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY B ESUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS

PHYSICIAN NAME	PHYSICIAN TELEPHONE NUMBER
PHYSICIAN ADDRESS	
PHYSICIAN SIGNATURE	\DATE

Physician Certification is good 60 days from date of physician's signature

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PAYMENT OF TRANSFER CHARGES

Addressograph

Patient's Name _____

I understand and agree that I will be responsible to arrange payment for all transferring charges that may not be covered by my insurance.

_____ _____

Date/Time Signature of Patient/Legal Representative

_____

Witness

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TRANSFER CHECK LIST

	YES	NO	N/A
1. Medical screening completed and documented by MD in PROGRESS NOTES or medical record			
2. Medical stabilization achieved prior to transfer and documented in PROGRESS NOTES. MD completes and signs PHYSICIAN CERTIFICATION FOR TRANSFER			
3. If unstable, but medical benefits outweigh risk, MD documents risks and benefits discussed with patient in PROGRESS NOTES. MD completes and signs PYSICIAN CERTIFICATION FOR TRANSFER			
4. If patient refuses stabilization, have patient sign REFUSAL OF STABILIZATION FORM and MD must document refusal in PROGRESS NOTES or medical record			
5. MD contacts receiving MD and documents acceptance in PROGRESS NOTES and HOSPITAL TRANSFER ORDERS			
6. MD documents accepting hospital in PROGRESS NOTES and on HOSPITAL TRANSFER ORDERS			
7. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION • Type of information checked off in box on line 2. • Institution to receive information filled on line 3. • Signed by patient/legal representative on line 9			
8. Medical records copied and placed in envelope and given to EMS. Make sure to record initials in lower left hand corner of AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION			
9. MD to select mode of transfer. Line 4 of HOSPITAL TRANSFER ORDERS and complete PHYSICIAN'S MEDICAL NECESSITY CERTIFICATION			
10. Nurse completes and obtains consent from patient on bottom half of PHYSICIAN CERTICATION for TRANSFER			
11. Patient signed PAYMENT OF TRANSFER CHARGES			
12. PATIENT TRANSFER FLOWSHEET INTERHOSPITAL TRANSFER completed and report time and to whom recorded at bottom of sheet and in NURSE'S NOTES			
13. Vital signs take immediately prior to transfer and time of transfer documented			
14. All documentation legible			
15. White originals of carbons stay with chart			
16. Updated home medication list sent to receiving institution.			
17. Physician must sign HOSPITAL TRANSFER ORDERS			

<u>DO NOT</u> PROCEED WITH TRANSFER OF PATIENT UNTIL ALL ITEMS CAN BE ANSWERED.

(FORWARD THS FORM TO THE DEPT. DIRECTOR WHEN TRANSFER COMPLETE **Signature _____**

Signature Dept. Director _____ **Signature Auditing Nurse _____**