**SAMPLE EMERGENCY DEPARTMENT PATIENT TRANSFER OR DISCHARGE FORM**

Patient Name: ___________________________ Number: ___________________________

<table>
<thead>
<tr>
<th>PHYSICIAN CERTIFICATION</th>
<th>[To be completed by physician if patient transferred or discharged from ED].</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ No emergency medical condition. The patient has received a medical screening exam, but the patient does not have an emergency medical condition.</td>
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<tr>
<td>✗ Stable. The patient has an emergency medical condition, but the condition is stable. No material deterioration is likely to result from (1) a transfer to another facility or (2) discharge with instructions for appropriate follow-up care.</td>
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<tr>
<td>✗ Transfer is in patient's best interests. The patient has an unstable emergency medical condition, but the benefits of discharging or transferring the patient outweigh the risks to the patient as described below:</td>
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1. Benefits of transfer:  
   - Specialized equipment or services at the receiving facility [describe]: ___________________________
   - Other [describe]: ___________________________

2. Risks of transfer:  
   - Deterioration of medical condition during transfer.  
   - Delay in treatment due to transfer.  
   - Other [describe]: ___________________________

Physician: ___________________________ Date and time: ___________________________

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<tr>
<th>TRANSFER CHECKLIST</th>
<th>[To be completed by ED nurse when the patient is transferred to another facility].</th>
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</table>
| 1. Patient Consent or Request for Transfer. The patient has been informed of their EMTALA rights and the risks and benefits of transfer. After being informed, the patient or their representative:  
   - Consents to the transfer recommended by the physician. [Complete Patient Transfer Consent form].  
   - Requests the transfer against the advice of the physician. [Complete Patient Transfer Consent form].  
   - The Hospital is or was unable to obtain written consent from the patient or their representative because: |

| 2. Accepting Facility:  
   - The facility was contacted; has the capability and capacity to provide appropriate treatment; and has agreed to accept the transfer and provide appropriate treatment to the patient.  
   - Name of person at facility who agreed to accept transfer: ___________________________  
   - Name of person at this Hospital who contacted accepting facility: ___________________________  
   - Date/time of contact: ___________________________ |

| 3. Method of Transportation.  
   - Private vehicle.  
   - Ambulance with appropriate equipment and practitioners.  
   - Aircraft with appropriate equipment and practitioners.  
   - Other [describe]: ___________________________  
   - Name of transporting entity: ___________________________  
   - The patient was offered but refused the recommended method of transport. [Complete Patient Transfer Consent form]. |

| 4. Records. Copies of the following records have been sent to the accepting facility:  
   - History, physical, consultations and progress notes.  
   - Nursing observations.  
   - Laboratory and other test results.  
   - Patient consent for transfer or physician certification.  
   - Name and address of any on-call physicians who failed to respond.  
   - Other records relevant to the emergency care.  
   - Additional records will be sent when available.  
   - Nurse or other appropriate person: ___________________________ Date: ___________________________ |