MARINHEALTH MEDICAL CENTER

PATIENT TRANSFER CHECKLIST: REQUIRED DOCUMENTATION

Patient Name: DOB:

Thank you for referring the above patient for transfer. To ensure continuity of quality patient care, the following documentation **must accompany** the patient during transfer/transport.

Please confirm (X) each of the following and **FAX this completed form to the MarinHealth Transfer Center (415-461-8158)**

- ☐ Transfer Summary: **MUST BE FAXED** with Transfer Agreement Signature Page **PRIOR** to patient transport
- ☐ Current Inpatient Medication Record/including medication reconciliation
- ☐ Discharge Summary
- ☐ H&P or ED notes
- ☐ Nursing Records with Current Vital Signs
- ☐ Advanced Directive (if available)
- ☐ **ALL Diagnostic Studies**
  (*CT, Echo, X-rays, EKG, MRI, Cath Lab Written/Dictated Report(s)*)
- ☐ **All Films or Images on a disc MUST accompany patient at the time of transfer. All angiographic studies must accompany cardiac patients with images provided on a disc**
- ☐ All Clinical Lab Studies, including Microbiology

MARINHEALTH MEDICAL CENTER

PATIENT TRANSFER AGREEMENT

SIGNATURE PAGE

MarinHealth Medical Center has received a request to accept this patient as a TRANSFER from your facility. This confirms your agreement that at the request of MarinHealth, you will accept the patient in return transfer upon reasonable notice from MarinHealth Medical Center to do so, and will designate an Attending Physician to provide care for this patient. Since the transfer of this patient is not an emergency situation or covered under EMTALA, your facility agrees to comply with the conditions of admission of MarinHealth Medical Center and agrees to be responsible for the costs associated with the transfer back of this patient to your facility. The terms and obligations set forth in the executed Transfer Back Agreement between the parties shall govern each individual transfer back agreement. This individual transfer back agreement shall not be altered by either party.

Patient's Name _____ *Date of Birth* _____

Hospital Name _____

Transferring Physician

Print Name and Title _____

Signature _____

Date _____

Contact Telephone Number or Pager Number _____

Referring Hospital Representative

Print Name and Title _____

Signature _____

Date _____

Contact Telephone Number or Pager Number _____

Patient/Responsible Family Member

Print Name and Relationship to Patient _____

Signature _____

Date _____

*Telephone Number*_____