Index: 6080.000
Addendum: #1A

PATIENT CONDITION:

- ☐ The individual has been stabilized such that within reasonable medical probability, no material deterioration of individual's condition or the condition of the mother and/or unborn child(ren) is likely to result from transfer.
- ☐ The individual's condition has not been stabilized, however, based on the information available to me at the time of transfer, expected benefits of transfer outweigh the risks associated with transfer.
- ☐ The individual is in labor. However, based on the information available to me at the time of transfer, the expected benefits of transfer outweigh the potential risks to the mother and/or unborn child(ren) from effecting the transfer.
- ☐ Other:

RISKS/BENEFITS: I have examined the patient and explained the following risks and benefits of being transferred/refusing transfer to the patient.

The Benefits are: _____

The Risks are: _____
All transfers have the inherent risks of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence.

TRANSFER REQUIREMENTS (✓ when completed) The receiving hospital has agreed to accept transfer and to provide appropriate and necessary medical treatment and has available space and personnel.

1. ☐ The receiving facility: _____ ☐ Accepting Physician: _____ ☐ Accepting Admitting Personnel _____
2. ☐ Medical Record copied and sent with patient ☐ EKG's ☐ Lab Data ☐ Copies of Radiology Exams
3. ☐ Transfer personnel needed: ☐ RN ☐ EMT ☐ MD ☐Other (Specify): _____
4. ☐ Mode of Transfer: ☐ Helicopter _____ ☐ Ambulance _____
5. ☐ Name and address of on-call MD who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment _____

SIGNATURE OF TRANSFERRING PHYSICIAN:

TRANSFER CONSENT (To be completed by patient)

I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended that I be transferred to the service of Dr _____ at _____ The potential benefits of such transfer, the potential risks associated with such transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. With this knowledge and understanding, I agree and consent to be transferred, and my consent includes my authorization for the release of my medical records to the receiving facility

Signature of patient or legally responsible individual signing on the patient's behalf	Witness:
Relationship to Patient	Date & Time:

Hackettstown Community Hospital will make arrangements with an independent transport company for the appropriate method of a patient's transfer regardless of the patient's financial status or ability to pay. Payment for this transportation will be arranged separately between the transport company and the patient.

(Addressograph)

HACKETTSTOWN COMMUNITY HOSPITAL

CONSENT/REFUSAL TO TRANSFER

6/96

PATIENT INITIATED TRANSFER REQUEST (To be completed by patient)

You are hereby notified that Hackettstown Community Hospital has the following obligations pursuant to Federal Law [42 U.S.C. 1395dd(c) (1) (A) (i)]: The Hospital must provide a medical screening examination to any person presenting at the emergency department to determine whether the individual suffers from an emergency medical condition. If such a medical condition is present, the Hospital must provide such further examination and treatment as required to stablilize the medical condition. If the Hospital determines that it is in the best interest of the individual (or, in the case of a pregnant woman, the woman or her unborn child) to transfer the individual to another medical facility, the Hospital must require your physician to execute a transfer certification complying with the standards of the law and must provide an appropriate transfer.

I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended and offered to me further medical examination and treatment. The potential benefits of such further medical examination and treatment as well as the potential risks associated with transfer to another facility have been explained to me and I fully understand them. In spite of this understanding, and after considering the above information, I request transfer to _____ _____because _____ _____.

This request includes my authorization for the release of my medical records to such facility.

Signature of patient or legally responsible individual signing on the patient's behalf:	Witness:
Relationship to patient:	Date & Time:

TRANSFER REFUSAL (To be completed by patient)

I acknowledge that my medical condition has been evaluated and explained to me by the Emergency Department physician or other qualified medical person and/or my attending physician, who has recommended that I be transferred to the service of Dr. _____at _____ _____. The potential benefits of such transfer, the potential risks associated with such transfer, and the probable risks of not being transferred have been explained to me and I fully understand them. Even though Dr. _____ _____ believes it is in my best interest to be transferred, I refuse to be transferred because _____ _____ _____and I request, instead, to continue receiving treatment at Hackettstown Community Hospital.

Signature of patient or legally responsible individual signing on the patient's behalf:	Witness:
Relationship to patient:	Date & Time:

Hackettstown Community Hospital will make arrangements with an independent transport company for the appropriate method of a patient's transfer regardless of the patient's financial status or ability to pay. Payment for this transportation will be arranged separately between the transport company and the patient.

6/96

PATIENT'S NAME: _____

I.D. # _____

DATE OF TRANSPORT: _____

DIAGNOSIS: _____

ORIGIN: _____ UNIT: _____

DESTINATION: _____ UNIT: _____

REASON FOR TRANSPORT: _____

MODE OF TRANSPORTATION: (CHECK ONE)

_____ Critical Care Transport
_____ Emergency Ambulance
_____ Basic Life Support
_____ Wheelchair Van Service
_____ Passenger Vehicle

ADDITIONAL STAFF NEEDED:

_____ Registered Nurse ACLS Certified
_____ Registered Nurse
_____ Licensed Practical Nurse
_____ Extra EMTs
_____ Respiratory Technician
_____ Physician

TREATMENT DURING TRANSPORT:

_____ Follow current ACLS protocol prn (standing orders provided)
_____ Cardiac Monitoring
_____ External Pacing
_____ IV Therapy
_____ Oxygen Therapy _____ 1pm _____ cannula _____ simple face mask _____ venturi mask % _____ non rebreather _____
_____ Suctioning
_____ Artificial Ventilations
_____ bag valve mask
_____ portable vent _____ settings _____
_____ Drugs: **** Please specify dosage and route**

1. _____
2. _____
3. _____
4. _____

(Addressograph)

HACKETTSTOWN COMMUNITY HOSPITAL
651 Willow Grove Street
Hackettstown, NJ 07840 - 908-852-5100

MEDICAL NECESSITY FORM

10/96

MEDICAL NECESSITY FORM (Page 2)

HACKETTSTOWN COMMUNITY HOSPITAL
651 Willow Grove Street
Hackettstown, NJ 07840
908-852-5100

_____ Immobilization
- _____ C-Spine
- _____ Short Board
- _____ Long Board
- _____ Hare Traction
- _____ Thomas Half Ring
- _____ Abductor Pillow

TREATMENT CONT.

_____ Ked
_____ Halo
_____ Restraints (check restraints necessary)
_____ 4 pt
_____ Waist Only
_____ PRN
_____ Vital Signs q _____ minutes _____ q _____ hours
_____ Neurological Checks

ADDITIONAL COMMENTS/INSTRUCTIONS: _____

_____

_____

_____

_____

_____

_____

Physician's Name (Print) _____

Physician's Signature _____

Date _____

PATIENT NAME: _____

I.D. #: _____

DATE OF SERVICE: _____

TRANSPORT REGISTERED NURSE'S NAME: _____
(Please Print)

TRANSPORT RN ACLS: _____
(Signature)

RECEIVING RN NAME: _____
(Pleae Print)

RECEIVING RN: _____
(Signature)

(Addressograph)

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MEDICAL TRANSPORTATION NURSES NOTES

10/96