TRANSFER CHECKLIST (Ground / Air)

Patient name: ________________________________ D.O.B.____________

****

Staffing Info:

[ ] Staffing notified of transfer with pertinent information

[ ] Willmar Ambulance Interfacility Transfer Guideline form completed and faxed to staffing (# 4071). Original kept with the chart. (level of care needed for transport documented & saved for audit)

Nursing Info:

[ ] Air Ambulance transfers - Switchboard called immediately after contact with air transport service and estimated time of arrival (ETA) shared.

[ ] Receiving hospital called for bed availability / *note on Transfer Consent form*

[ ] Physician to Physician contact made for accepting patient / *note on Transfer Consent form*

[ ] Please contact the Admission Point Nurse (APP) to verify appropriate level of care prior to transfer (excludes ER transfers)

[ ] Transfer Consent form completed & signed by transferring physician. *(Original kept with chart and copy to Ambulance staff.)*

[ ] Ambulance PCS form completed & signed by transferring physician. (*Original kept with chart and copy to Ambulance staff.)*

[ ] Interfacility transfer orders form completed & signed by transferring physician (*Original kept with chart and copy to Ambulance staff.)*

[ ] Request and obtain copies of x-rays, CTs, etc. from Radiology

[ ] Appropriate records copied, including face sheet, and checked on Transfer Consent Form. (All copies of records sent with patient)

[ ] Receiving hospital nursing unit called with patient report / discharge vitals recorded / *note on Transfer Consent form*

[ ] Completion of Critical Care Incoming Team Handoff (if applicable - see box #14 on Transfer Consent Form)

Patient Info:

[ ] If patient does not have a Foley catheter, have patient void just prior to departure consider Foley placement on all OB and trauma patients

Family Info:

[ ] Family notified of transfer and maps or directions given.

DT0116

Willmar Ambulance Interfacility Transfer Guidelines

[ ] **BLS-Category** (No transfer order sheet needed)

1. IV Infusions on pumps at TKO rates - No medications ordered or hanging
2. No orders or patient need for medications of any kind en-route

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[ ] **ALS-Category**

1. Orders for IV, IM or Oral meds
2. Cardiac monitoring
3. IV Infusions with Medication Mixed in bag
4. Titration of vasoactive or antidysrhythmics infusions
5. Post thrombolytic infusion
6. Blood products confirmed and hanging, second bag confirmed and able to be started en-route
7. ET Tube / Trach-with or with out ventilator need
8. External pacing or potential need for it
9. Chest tubes already in place

Critical Care / OB-Category / STEMI / Stroke

[ ] 1. Patient is hemodynamically unstable and requires advanced interventions
2. Invasive Line Monitoring
3. Fetal Heart monitoring
4. Stroke

[ ] **STEMI Transfer**

[ ] **Code Stroke Transfer**

BLS = Basic medical need for stretcher transfer. Condition is stable, no material deterioration of condition is likely to result from or occur with transfer.

ALS = Condition is stable, or has been stabilized and need for critical care is not anticipated.

***CC = Patient who is unstable, requiring continued stabilizing efforts en-route. Advanced procedures or medications need to be given. (Also to include STEMI patients, code stroke patients)**

OB = Patient requiring fetal monitoring or has Mag Sulfate running.

***CC category patient transfers - (Non-OB) can be staffed with the following teams:**
paramedic / nurse; paramedic / paramedic; paramedic / RT; paramedic / EMT
staffing will be determined by availability of staff and care needs of the patient at the time of transfer.

Hospital with Bed Available ______________________________

Name of Patient: ______________________ D.O.B. ____________ Room # __________

______________________ ____________ ____________
Signature Date Time

Completed form to be faxed to Staffing #4071

DT0368

TRANSFER CONSENT

This hospital is required by federal law to provide any presenting patient with a medical screening examination to determine whether an emergency medical condition exists and to provide necessary stabilizing care within its capabilities for emergency medical conditions without regard to means or ability to pay. This hospital does participate in Medicare and Medicaid.

PHYSICIAN SECTION

1. Reason for Transfer
- [ ] Need for higher level of care not available at RMH
- [ ] Need for diagnostic equipment not available at RMH
- [ ] Patient/responsible person's request.
- [ ] Appropriate service/resource not at RMH

List: ______________________________

2. [ ] **Alternatives** to transfer discussed with patient:
[ ] **None**
List if any ______________________________

3. ACCEPTING PHYSICIAN:

______________ ______________
Name Time of Acceptance

4. DIAGNOSIS

____

5. PATIENT CONDITION

A. [ ] There is no reasonable likelihood of deterioration from or during transport.

B. [ ] The patient may be at risk for deterioration from or during transport, but benefits outweigh the risks.

C. [ ] Patient is pregnant - contractions

6. LEVEL OF TRANSFER (Must check a level)
(If patient / family refuses level of transfer assigned, see # 10)
Qualified personnel will transfer the patient.

[ ] BLS Ambulance [ ] Critical Care Ground
[ ] ALS Ambulance [ ] Critical Care Flight

7. RISKS OF TRANSFER
- [ ] Cardiac decompensation
- [ ] Pulmonary decompensation
- [ ] Bleeding
- [ ] Deterioration of medical condition: ______________
- [x] Vehicular accident/transport hazards
- [ ] Death

Based upon my examination of the patient and the information available to me at the time of transfer, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility. I have explained this to the patient / patient's legally responsible representative

__________ __________ ______________________
Date *Time* *Physician Signature*

HOSPITAL SECTION

8. DATE OF TRANSFER ______ / ______ / ______

9. HOSPITAL ACCEPTANCE OF TRANSFER

A. Name of destination hospital: ______________________________

B. Accepted by: ______________________________
Name of person at Destination Hospital Time

C. Acceptance obtained by ______________
RMH Staff Person

10. PATIENT CONSENT TO TRANSFER

I understand the risks and benefits of my transfer.
- [ ] I hereby CONSENT to transfer with the recommended mode of transport.
- [ ] I hereby consent to transfer but refuse the recommended mode of transport.
- [ ] Patient involuntary transfer (72 hour hold)
- [ ] I hereby REFUSE transfer.

____
Patient signature or patient's legally responsible representative

____
Reason patient unable to sign

____
Witness

11. TRANSPORTATION

Service contacted: ______________
By ______________ Time ______
RMH Staff Person
ETA ______________

12. See Medical Record for VS.

Report given to ______________ **By** ______________
Receiving Hospital RN RMH RN

13. COPIES OF MEDICAL INFORMATION
- [ ] Medical Record
- [ ] X-ray / Lab
- [ ] Face Sheet
- [ ] Transfer Summary
- [ ] Other
- [ ] EKG
- [ ] Medication/IV's
- PKU [ ] Done [ ] Not Done
- [ ] Hold Order
- [ ] Medical Stability Statement

14. INCOMING TEAM or Ambulance Service

Incoming Team ______________ assumed care at ______
Name of Team Time

Report/Hand off given to ______________ by ______________
Receiving team RMH RN

Original kept with the chart
Copy goes with patient

Transfer Consent
1/13
8010-0256-29

Mainkeepeer: ESD

DT0001

ALS and Critical Care Orders

Interfacility Transfer Orders

ALS and CC transfer orders only (* BLS do not need orders form)

1. Transfer to ______________________________________
   (facility)
2. ______ 02, Titrate as needed ______ Liters per _________
3. ______ Telemetry.
4. ______ Maintenance fluids __________ at ______ml per hour.
5. ______ Albuterol / Atrovent Nebs up to max of ______ treatments.
6. ______ Pain Control
   - ______ Morphine Sulfate ________ mg up to a max of________
   - ______ Other - ____________________________
7. ______ Sedation
   - _____ Ativan (Lorazepam) ________ mg up to a max of ________
     (Use concurrently with an analgesic)
   - ______ Utilize Agitation Protocol
   - ______ Other ______________________________
8. ______ Intubated Patients
   - ________ Vecuronium 0.1 Mg/Kg Q 30-45 minutes PRN
   - ________ Versed 5-10 Mg Q 15-30 minutes PRN
   - ________ Propofol titrate to effect (if already started)
9. ______ Nausea and Vomiting
   - ______ Zofran 4 mg IV or IM (call if additional meds needed)
   - ______ Other ______________________________
10. Medication drips:
    - ______ Nitroglycerin - Titrate as needed for pain, maintaining a SBP greater than 100.
    - ______ Heparin drip per protocol.
    - ______ Dopamine - may titrate as needed for BP of _________, or a max of _______mcg/kg/min
11. Other orders specified by physician:

____

____

This patient is _______Full resuscitation efforts _______/or _____DNR/DNI________

Physician Signature ______________ Date ______________ Time ______________

Interfacility Transfer Orders
5/13
7480-0204-29
Mainkeeper: ESD

Physician Certification Statement
for Ambulance Transportation

Rice Staffing Phone 320-231-4212
Sheriff's Dept. Dispatch Center 320-235-1260

Section 1 - Beneficiary Information

Patient Name:	Diagnosis:
Date of Transport:	Medicare / Medicaid #:
Pickup:	Destination:

Section 2 - Medical Necessity Information for non emergency transportation (answer 1 through 5)

[ ] Yes [ ] No 1. Can the patient be safely transported by car, taxi, bus or a wheelchair van, seated for the duration of the transport, and without a medical attendant? If **Yes**, the patient **does not meet** the criteria for stretcher transportation.
[ ] Yes [ ] No 2. Is the beneficiary unable to get up from bed without assistance?
[ ] Yes [ ] No 3. Is the beneficiary unable to ambulate?
[ ] Yes [ ] No 4. Is the beneficiary unable to sit in a chair or wheelchair?

5. Please describe the medical reason(s) why the patient required monitoring and/or transport by stretcher.

____

Section 3 - Hospital to Hospital Transfers Only (answer 6 through 11)

[ ] Yes [ ] No 6. Is the patient being transferred to a higher level of care?
7. Describe medical facilities or procedures required/available at destination facility not available at originating facility?

____

[ ] Yes [ ] No 8. The patient was discharged from the originating facility.
[ ] Yes [ ] No 9. The patient is being transported to the closest appropriate facility.
If **No**, describe why the patient has to be transported to the further facility.

____

If **No**, the patient/family has been notified they will be responsible for the additional mileage charges beyond the closest appropriate facility [ ] Yes [ ] No
[ ] Yes [ ] No 10. The patient is critically ill or injured, unstable, or in need of immediate intervention.

Air Ambulance - ONLY
[ ] Yes [ ] No 11. Due to the medical condition of the patient and/or the need for rapid transport, the patient requires transport by AIR AMBULANCE.

Section 4 - Signature

LEGIBLY PRINT the FULL name of the Physician or Health Professional ordering transport that **signed** this **PCS**:

______________________________ Physician NPI:______________________________ (if known)

SIGNATURE of Physician* or Healthcare Professional ordering transportation:

______________________________ Date: ______________________________

Check appropriate box for the professional that signed this form:
[ ] Physician [ ] RN [ ] Discharge Planner [ ] Nurse Practitioner [ ] PA [ ] Clinical Nurse Specialist

***Physician must sign for scheduled or repetitive transports**. For unscheduled ambulance transports, the form may be signed by any of the above if the attending physician is unavailable to sign.

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional medical opinion, this patient requires transport by an ambulance and should not be transported by any other means. I understand that this information will be used by CMS to support the determination of medical necessity.

Ambulance Transfer Communication Process

Staffing receives a call and fax information from medical care unit requesting a BLS, ALS or CC, STEMI transfer

Staffing pages out transfer info on Emergin and includes destination, time for departure, and name and ext number of unit coordinator on unit or RN calling for transfer

Critical Care STEMI transfer or Requests from other hospitals
EMS crew taking transfer
• immediately contacts nurse on unit or ER RN at number provided on the page for patient information
Staffing will call dispatch to page for immediate Ambulance response by the 911 crew or B/U crew if 911 is out on a call

Ambulance Crews responds to location for transfer. These are to be treated like 911 calls for time lines

EMS crew taking transfer
• immediately contacts nurse on unit or ER RN at number provided on the page for patient information
• If 911 crew is on a call, the B/U crew makes the calls by phone immediately
• confirms departure time and/or discusses transfer delay issues related to staff coverage (ie dropping to BLS coverage in town) or 911 calls currently in progress to a mutual resolution

Following conversation with nurse on unit or ER RN:
• EMS crew immediately calls staffing with departure time
• staffing contacts dispatch to page out transfer
• EMS crew arrives 15 minutes prior to leave time for patient report and patient loading