



**PROVIDER CERTIFICATION AND
PATIENT CONSENT FOR TRANSFER**

PATIENT'S NAME:

PATIENT'S SSN (999-99-9999):

FACILITY:

In my medical opinion, this patient does not have an emergency medical condition or the condition has been stabilized.

Provider's Signature

Date (MM/DD/YYYY)

Time

If an emergency condition exists, the responsible physician must sign the following certification prior to transfer.

The patient does not request transfer, but it is my opinion, based on the information available to me at this time, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the risks of the transfer. (Any facility transferring patients with unstabilized medical conditions must provide medical treatment, within its capacity, to minimize the risk to the individual; send all pertinent medical records, including advanced directives; effect the transfer using qualified personnel and equipment; and obtain consent of the receiving facility.)

ADDITIONAL COMMENTS:

Provider's Signature

Date (MM/DD/YYYY)

Time

CONSENT TO TRANSFER

I consent to be transferred to _____

Name of Facility

I have been informed of the benefits and risks of this transfer. The most significant risks are:

Patient's Signature

Date (MM/DD/YYYY)

Time

Witness's Signature

Date (MM/DD/YYYY)

Time