MEMORANDUM OF TRANSFER

1. **Transferring Hospital:** *Acuity Hospital of Houston*
   Address: *2001 Hermann Drive*
   City, State, Zip: *Houston, Texas 77004* Phone: ____
2. **Patient Information (if Known):**
   Full Name: ____
   Address: ____
   City, State, Zip: ____ Phone: ____
   Sex ☐ Male ☐ Female Age: ____
   Race ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other: ____
   National Origin: ____ Religion: ____
   Physical handicaps: ____
3. **Next of Kin Information (*if Known*):**
   Full Name: ____
   Address: ____
   City, State, Zip: ____ Phone: ____
   Notified: ☐ Yes ☐ No
4. **Date of Arrival:** ____ Time: ____
5. **Initial Contact with Receiving Hospital:**
   Date: ____ Time: ____
   Name of Contact Person at Receiving Hospital:
   ____

   Transferring Hospital Administrative Person's Signature and Title Who Contacted Receiving Hospital:
   ____
   Name: ____ Time: ____
   Title: ____ Date: ____
6. **Receiving Physician Secured by Transferring Physician:**
   Date: ____ Time: ____
   Receiving Physician: ____
   Address: ____
   City, State, Zip: ____
7. **Transferring Physician:** ____
   Address: ____
   ____ Phone: ____
8. **Receiving Hospital Secured by Transferring Hospital:**
   Date: ____ Time: ____
   Name and Title of Receiving Hospital Administrative Person:
   ____
9. **Receiving Hospital:**
   ____
   Address: ____
   City, State, Zip: ____ Phone: ____
10. **Type of Transferring Vehicle and Company Used:**
   Name of Company: ____
   Equipment Needed: ____
   Method of Transfer: ☐ Ground Ambulance ☐ Air Ambulance
   ☐ Private Car ☐ Police Sheriff ☐ BLS ☐ ALS ☐ MICU
   Time Contacted: ____ ETA: ____

   Personnel Needed for Transport: ☐ EMS ☐ R.T. ☐ Nurse ☐ Physician
   ☐ Police Sheriff ☐ Other ____
11. **Attachments:**
   ☐ X-rays ☐ Physician Progress Notes ☐ ABGs
   ☐ Lab Reports ☐ Nursing Progress Notes ☐ EKG's
   ☐ H & P ☐ Medication Record ☐ Other: ____

12. **Diagnosis:** ____
13. **Vital Signs at Time of Transfer:** Time: ____
   Temp: ____ HR: ____ Resp: ____ BP: ____
14. **Physician Certification:**
   Risk and benefits of transfer (or refusal of transfer) have been explained by me to the patient legally responsible representative as follows:

   Summary of Benefits of transfer: ☐ **Specialized Treatment of Care**
   ☐ **Improved Possibility of Retaining Life or Limb** ☐ **Continuity of Care**
   ☐ **Further Medical Exam** ☐ **Radiologic Procedures Not Available Here**
   ☐ **Invasive Procedures / Testing Not Available Here**
   ☐ **Other:** ____

   Summary of risks of transfer: ☐ **Death** ☐ **Pain Delivery in Route**
   ☐ **Worsening of Condition** ☐ **Motor or Other Vehicle Accident**
   ☐ **Loss of Function of Afflicted Body Part** ☐ **Other:** ____

   Summary of risks of non-transfer: ____
   ____

   Based on the information available at the time of transfer, the medical benefits reasonable expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk of the transfer to the patient and in the case of labor, to the unborn child
   Signature of Transferring Hospital Physician:
   ____
15. **Patient Being Transferred for**
   ☐ Medical necessity Upgrade in care
   ☐ **STABLE at transfer** ☐ **Yes** ☐ **No**
   ☐ **EMERGENCY transfer** ☐ **Yes** ☐ **No**
   ☐ Physician Request ☐ Preferred Provider
   ☐ Patient Request If Patient Request, reason for request: ____
   ____
16. **Name and Address of On-Call Physician Refusing or Failing to Appear to Provide Stabilizing Treatment:** ____
   ____
17. **PATIENT REQUESTED TRANSFER / CONSENT TO TRANSFER**
   ☐ I acknowledge that the risks and benefits of transfer have been explained to me
   ☐ I have been informed of Acuity Hospital of Houston obligations under EMTALA.
   ☐ I understand the risks and benefits as they have been explained to me I have considered these and risks and benefits and consent to transfer to another medical facility. With this knowledge and understanding
   ☐ **I agree and consent to transfer**
   ☐ **I request a transfer**
   ☐ **I refuse the transfer**
   Signature of patient or legally responsible representative:
   ____ Relationship to Patient: ____

   Witness ____ Date: ____ Time: ____
18. **Personal Belongings (check all that apply)**
   ☐ Sent with Family
   ☐ Sent with Patient
   ☐ Given to: ____

SECTION B: (To be Filled Our At Receiving Hospital) Acknowledgement of Memorandum of Transfer

1. **Name of receiving Hospital:** ____
   ____
   Address: ____
   City, State, Zip: ____ **Phone:** ____
2. **Date of Arrival:** ____ **Time:** ____
3. **Receiving Hospital Administrative Signature:**
   ____

Title: ____
Date: ____ **Time:** ____

4. **Receiving Physician Assuming Patient Responsibility**
   Name: ____
   Address: ____
   City, State, Zip: ____
   Date: ____ **Time:** ____
   Receiving Physician's Signature:
   ____
5. **If response to transfer request was delayed beyond thirty (30) minutes, document the reason(s) for delay, including any time extensions agreeed to by the transferring facility. Use additional sheet, if necessary.**
   ____

Instructions: The transferring hospital completes Section A and sends the original (white) page plus the attachments required by section 11-29 of the Hospital Licensing Standards with the patient to the receiving hospital and retains the copies. The receiving hospital completes Section B and retains the original form. Both hospitals must file the MOT from the patient's medical record and in a manner which will facilitate its inspection by the Department of State Health Services.

WHITE - Send to Patient YELLOW - Medical Record PINK - Nursing Administration