Mount Sinai

Mount Sinai Health System
New York

Transfer Consent

Medical Condition:

Condition (Required, Check one): ☐ Stable ☐ Critical

Diagnosis (Required): _____

Reason for Transfer/Benefit (Required, Check all that apply):

☐ Expedite Bed Assignment ☐ Higher Level/Specialty Care ☐ Patient Preference ☐ Continuity of Care

Other Reason for Transfer (if applicable): _____

Risks:

All transfers have the inherent risks of traffic delays, accidents, bad weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle if there is a change in my medical condition on the way to the facility.

Other risks including those related to the patient's medical condition (required but if not applicable, leave blank):

_____

Patient Consent to Transfer

The attending physician(s) or designee below have explained to me, in my preferred language, the potential risks and benefits of my transfer specific to my medical condition. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient,* Guardian or Representative**	*Print name*	*Signature*	*Date*	*Time*	*Relationship or "self"*
Signature Witness	*Print name*	*Signature*	*Date*	*Time*	☐ Witnessed Patient confirming signature *(check box if applicable)*
Preferred Language Interpreter Name or Number	*Print name and/or number*	*Signature (if present)*	*Date*	*Time*	☐ Patient refused interpreter *(check box if applicable)*

☐ **Telephone/Video Consent with Representative** (Check box if applicable)**

Name of designee appointed by Attending Physician to explain the risks and benefits of transfer for the patient's medical condition if applicable:

_____

Printed name of designee (If not applicable, leave blank)

Attending Physician Certification of Transfer

I hereby certify that based on the information available to me at the time of transfer, to a reasonable degree of medical certainty, the expected medical benefits from the provision of appropriate care at another facility outweigh the risk to the individual or unborn child. I have confirmed that this patient/representative** is able to give informed consent. If the patient is unable to provide consent and does not have a representative**, a second attending physician has concurred with the appropriateness of the transfer (Complete FHCDA Form 3). I have explained the risks and benefits of the transfer to the patient/representative** specific to their medical condition. I have offered to answer any questions and have fully answered all such questions . In the event that I was not present when the patient signed the form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

Print Attending Physician Name	*Attending Physician Signature*	*Date*	*Time*

*The signature of the patient must be obtained unless the patient is under the age of 18 or lacks capacity.
**Throughout this document, the term "representative" refers to a legally authorized representative or guardian.

Mount Sinai

Mount Sinai Health System
New York

转院同意书

医疗状况：

状况（必填，勾选一项）：　☐稳定　☐危急

诊断（必填）：_____

转院原因/益处（必填，勾选所有适用项）：

☐ 加快床位分配　☐ 更高级/专科护理　☐ 患者偏好　☐ 持续护理

其他转院原因（如适用）：_____

风险：

在前往医疗机构的过程中，如果本人的医疗状况发生变化，将面临所有转院都会面临的交通延误、事故、恶劣天气、恶劣地形或湍流以及车辆上设备和人员限制等固有风险。

其他风险，包括与患者医疗状况相关的风险（必填，如不适用，请留空）：

_____

患者同意转院

下列主治医生或其指定人员已使用本人的首选语言，向本人解释了与本人医疗状况相关的转院潜在风险和益处。本人有机会提出疑问，且本人的所有疑问均得到了满意的解答。

患者、* 监护人或代表**	_____ *正楷姓名*	_____ *签名*	_____ *日期*	_____ *时间*	_____ *关系或“患者本人”*
见证人签名	_____ *正楷姓名*	_____ *签名*	_____ *日期*	_____ *时间*	☐ 见证患者确认签名 *（如适用，请勾选方框）*
提供首选语言支持的口译员姓名或号码	_____ *正楷姓名和/或号码*	_____ *签名（如在场）*	_____ *日期*	_____ *时间*	☐ 患者拒绝使用口译员 *（如适用，请勾选方框）*

☐ **通过电话/视频通话取得代表**的同意（如适用，请勾选方框）**

主治医生任命的指定人员姓名，负责解释转院对患者医疗状况的风险和益处（如适用）：

_____

指定人员的正楷姓名（如不适用，请留空）

主治医生转院证明

本人在此证明，根据转院时获悉的信息，在合理的医学确定性范围内，在其他医疗机构接受适当护理的预期医疗益处大于对患者本人或胎儿的风险。本人已确认该患者/代表**能够给予知情同意。如果患者无法给予同意且没有代表**，则第二位主治医生已认可转院的适当性（填写 FHCDA 表格 3）。本人已向患者/代表**解释转院对其医疗状况的风险和益处。本人主动提出解答疑问并已充分解答所有此类疑问。如果患者签署该表格时本人不在场，则本人理解该表格仅能证明已完成知情同意过程。本人仍然有责任获得患者的同意。

_____ *主治医生正楷姓名*	_____ *主治医生签名*	_____ *日期*	_____ *时间*

*除非患者未满 18 岁或是无能力者，否则必须获得患者签名。
**在此文件中，术语“代表”是指法定代表或监护人。

注意：此文件必须作为患者医疗记录的一部分。