



MONTGOMERY COUNTY FIRE AND RESCUE SERVICE
EMERGENCY MEDICAL SERVICES SECTION

INTER-FACILITY TRANSPORT AUTHORIZATION

Requirements for Emergency Inter-Facility Transport

- ☐ This patient is an acutely ill or injured and is considered to be serious or life-threatening condition, justifying an emergency transport.
- ☐ The patient requires a special medical procedure or treatment that the hospital is unable to provide, or
- ☐ This patient meets one of trauma referral criteria listed in the MIEMSS *Interhospital Transfer Guidelines Manual*.
- ☐ An alternate means of emergency inter-facility transport is not immediately available.
- ☐ The transferring facility must provide a physician, registered nurse or other specialist to accompany the patient and be responsible for the administration of definitive patient care.
- ☐ The transferring facility must provide the medication, fluids and any specialized equipment that may be required for use on the patient during the transport, as well as copies of all patient records.
- ☐ The transferring physician agrees to be the on-line medical control physician during the transport.

TRANSFERING PHYSICIAN' S AUTHORIZATION

I hereby verify that _____ is in need of an
Patient's Name

EMERGENCY INTER-FACILITY TRANSPORT "and authorize MCFRS _____ to transport
EMS Unit

this patient to _____ at _____
Receiving Physician Receiving Facility

Physician' s Signature: _____ Date/Time: _____

DATA COLLECTION

A

Patient's Name: _____ Age: _____ Sex: _____

Transferring Facility: _____

Receiving Facility: _____ Unit/Room: _____

Receiving Physician: _____

Reason for Transfer: _____

Patient Diagnosis: _____

Special Precautions/Anticipated Complications: _____

Care/Equipment Needed During Transport: _____

Transferring Facility Personnel on Transport _____

B

Patient Assessment

Within 15 minutes of transport

Time: _____

Temp. _____

Pulse: _____

Resp. _____

B/P: _____

ECG: _____

Upon Arrival at Receiving Facility

Time: _____

Temp. _____

Pulse: _____

Resp. _____

B/P: _____

ECG: _____

C

Incident #: _____

Level: **ALS / BLS** **HOT / COLD**

Time of Dispatch: _____

Arrive at Transferring Hospital: _____

Depart Transferring Hospital: _____

Arrive at Receiving Hospital: _____

Receiving Physician Signature: _____