

Interfacility Transfer Guidelines for Children

Dear Hospital CEO:

As you may know, recent evidence shows that the best outcomes for critically ill and injured children are achieved when treated at facilities most prepared to address their needs.¹ In order to support improved emergency care of children in the State of Florida, the Florida Emergency Medical Services for Children Advisory Committee is providing the enclosed toolkit to assist Florida hospitals in aligning with state and national goals and objectives.

Interfacility Transfer Guidelines

The National Emergency Medical Services for Children (EMSC) program has established a goal to assist hospitals with **written interfacility transfer guidelines** that include the following components of transfer:

- A defined **process for the initiation of transfer**. This process includes the advance identification of groups or conditions of patients to be considered for transport and defines the roles and responsibilities of both referring and referral centers.
- A **selection process for determining the appropriate care facility**. Does the referring facility have a facility preference for patients with specific diagnosis or needs? Have the referring facilities established transfer agreements with the specialty facilities for specific services that it cannot provide (i.e. burn care, rehabilitation, etc.)?
- A **process for selecting the appropriately staffed transport service** to match the patient's acuity. Can the patient travel by basic or advance life support ambulance or does the patient need a specialty transfer team or air evacuation?
- A **process for the patient transfer** (including obtaining informed consent) that includes the necessary patient preparation (i.e., securing of airways, venous fluid/blood administration, etc.)
- A **plan for the transfer of patient information** (e.g. medical record, copy of signed transport consent), personal belongings of the patient, and provision of directions and referral institution information to family.

The attached Interfacility Transfer Form has been provided by the Florida Emergency Medical Services for Children (EMSC) program as a **model template and resource tool** to improve pediatric care across the continuum and to assist in meeting the above goals within the State of Florida. **This model is not a requirement of the State of Florida**, but is designed to be a resource. The layout of the form is as follows:

Pages 1 and 2: **Patient Transfer Worksheet**. This document is intended to support the referring provider in assessing the need for transport, most appropriate receiving facility, and most appropriate mode of transportation. The forms provide a convenient, consolidated set of information that can be utilized for verbal communications regarding the patient, as well as a hand-off tool when the transport service arrives.

Pages 3 and 4: **Consent for Transfer**. This document is intended to support the administrative documentation of the transfer process: patient condition, risks/benefits, and consent. Each facility may choose to modify this form. The form may also assist facilities in meeting documentation requirements of the Centers for Medicare & Medicaid Services (CMS) and Emergency Medical Treatment & Labor Act (EMTALA).



Interfacility Transfer Agreements

Another program goal of the National Emergency Medical Services for Children (EMSC) Program is to have established written interfacility transfer agreements that cover pediatric patients.

In order to determine how we can further assist your facility in providing the best pediatric pre-hospital care, the Florida EMSC Program will be surveying all Florida Hospitals with Emergency Departments on these two parameters (pediatric interfacility transfer guidelines and agreements).

Questions may be directed to Melia Jenkins, Florida EMSC Project Director, at 850.245.4440, extension 2773 or by e-mail at melia_jenkins@doh.state.fl.us.

To download an electronic copy of this toolkit and template, please visit www.fl-ems.com and go to the EMS for Children page.

¹Emergency Care for Children, Growing Pains, Institute of Medicine Report (2006), p. 86. Washington, DC: National Academies Press



Part I: Patient Transfer Worksheet

Patient Name: _____ Date/Time: _____

DOB: _____ Account Number: _____

Transfer Diagnosis *(Per Physician)*: _____

Weight: _____ Kg Allergies: _____

Initial Vital Signs:

Time: _____ Temp: _____ Heart Rate/Rhythm: _____

Resp: _____ BP: _____ SpO₂ _____ % on _____ % FiO₂ Glucose: _____

Pediatric Early Warning Score (PEWS): _____

Mode of Transportation Will Be *(Please check all that apply)*

<input type="checkbox"/>	Ambulance	<input type="checkbox"/>	Helicopter	<input type="checkbox"/>	Fixed Wing	<input type="checkbox"/>	Pediatric Transport Vehicle	<input type="checkbox"/>	Neonatal Transport Vehicle
<input type="checkbox"/>	Other _____								

Transport Agency: _____

Notification Time: _____ Arrival Time: _____

*Please ensure completion of **Part II: Consent for Transfer** or similar documentation

Verification of Transfer Acceptance:

Name of person accepting for receiving hospital *Title of person accepting for receiving hospital*

Date *Time* *Bed/Unit Assignment*

Name of person who obtained above information at sending hospital

Nursing Report: Patient report called to: _____ at: _____

Name of nurse at receiving hospital *Phone number*



Medical Records: (Copies)

- Face Sheet
- Chart
- Radiographic Images
- EKGs/ECHOs
- Laboratory Results/Specimens
- Consent for Transfer
- Other: _____

Personal Effects: The disposition of personal effects was:

- Family Member
- Patient
- Ambulance
- Other: _____

Final Vital Signs (at Time of Transfer):

Time: _____ Temp: _____ Heart Rate/Rhythm: _____
Resp: _____ BP: _____ SpO₂ _____ % on _____ % FiO₂ Glucose: _____

Airway/Breathing: O₂ Delivery Device: _____ Ventilator Settings: _____

Blood Gas Results (ABG/CBG/VBG): _____

Aerosol Treatment: _____ Time: _____

ETT Size: _____ Secured at: _____

Chest X-Ray to Verify ETT Placement? Yes No

Circulation: CPR Total Duration _____ minutes

Return of Spontaneous Circulation? Yes No If yes, time _____

Vascular Access: IV IO Location: _____ Catheter Size: _____

IV Fluids: Type: _____ Rate: _____ Total mL: _____

Medications, Dosage, Route, and Time Given: _____

Disability/Significant Medical History: _____

Home Medications: _____

Notification:

Parent/Legal Guardian aware of transfer? (Please Circle) YES NO N/A

_____, RN
Nurse's Signature *Date*

Nurse's Name Printed



Part II: Consent for Transfer

Patient Name: _____ Date/Time: _____

DOB: _____ Account Number: _____

Condition at Time of Transfer:

I hereby certify that based upon the information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another medical facility outweigh the increased risk to the individual, and in the case of labor, to the unborn child, from effecting the transfer:

- (Circle One Number)*
1. This individual has been stabilized such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer, or with respect to an obstetric condition, no risk to the unborn child is anticipated due to transfer.
 2. The patient is pregnant and having contractions.
 3. This individual has not been stabilized.

Reason for Transfer:

Risks of transfer include: _____
All transfers have the inherent risk of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel in the vehicle.

Benefits of transfer include: _____
The above risks and benefits of the transfer have been fully and completely explained to the patient or the responsible party by the physician who is certifying the transfer.

Physician's Acceptance:

I certify that the above-named patient has been accepted by Dr. _____

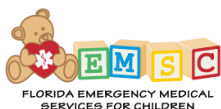
at _____
Accepting Facility

Sending Physician's Signature

Sending Physician's Name Printed

Nurse's Signature

Nurse's Name Printed



_____ **Patient/Guardian Consent for Transfer:**

I request and consent to my transfer and have been informed of the risks and benefits involved in the transfer. I authorize the release of any medical records or information to the receiving facility and/or physician. I acknowledge that I have received medical screening, examination and evaluation by a physician, or other appropriate personnel, and that I have been informed of the reasons for my transfer.

_____ **Patient/Guardian Request for Transfer:**

I, the undersigned, am being transferred at my request. I acknowledge that I have been informed of the risks and consequences potentially involved in the transfer. I hereby release the attending physician, and other physicians involved in my care, the hospital and its agents and employees, from all responsibility for any ill effects which may result from the transfer or delay involved in the transfer.

_____ **Patient/Guardian Refusal of Transfer:**

I acknowledge that Dr. _____ has advised me on the nature and advisability of the recommended services and their alternatives, their expected benefits, and the expected risks and complications associated with those services, and the probable consequences of not receiving them. I further acknowledge that my refusal to accept services could result in substantial and serious harm to my health and hereby release the hospital, its employees and agents, the physician(s) at the hospital on-call, and any other persons participating in my care from any responsibility whatsoever for unfavorable results which may occur as a result of my refusal.

Signature

Date

Time

Print Name

Relationship (if not patient)

Legal Guardian (Please Circle) Yes No

Parent/Guardian Cell Phone #

Witness to Signature

Print Name

If the patient cannot sign or if any of the above signatures cannot be obtained, explain why:

Physician's Signature

Date and Time

Print Physician's Name

