TRANSFER NOTIFICATION AND AGREEMENT

Transferring Facility: ___________________________ Date of Transfer: ___________________________

Referring Physician: ___________________________ Phone: ___________________________

Contact Person: ___________________________ Phone: ___________________________ Fax: ___________________________

Patient’s Name: ___________________________________________________________________________________

1. This is to confirm that UC San Diego Health (UCSDH) has received a request to accept the above patient as transfer from your facility.

2. The transferring facility will provide a summary, a copy of the appropriate portions of the medical record, diagnostic test results and all requested/appropriate diagnostic films to accompany the patient.

3. The transferring facility will not transfer the patient until the receiving physician has consented to accept the patient and the transfer has been cleared by the Transfer Center.

4. The transferring facility will ensure that the patient is medically stable and suitable for all procedures and treatments at the time of transfer.

5. This will confirm that the transferring facility and referring physician agree to accept the patient in return transfer at UCSDH’s request after specialty services provided by the UCSDH have been completed. UCSDH Physicians will transfer the patient back after they determine the patient can be safely treated within the capabilities of the facility. In the event that the transferring facility or its physicians are unwilling/unable to accept the patient back at that time, the transferring facility guarantees it will reimburse the UCSDH and its physicians for any services or days that are denied or not covered by the patient’s insurer, at the insurer’s customary reimbursement rate. In the instance that a patient is uninsured/covered, the UCSDH Medi-Cal per diem rate will apply.

6. Please specify an alternate-accepting physician with phone number if the referring physician is unavailable to accept the patient back.

7. Please specify contact person if other than the original from the transferring facility;
   
   Name: ___________________________ Title: ___________________________
   
   Phone number: ___________________________ Fax: ___________________________

8. ___________________________ agrees to be responsible for the transportation cost to and from ___________________________ not covered by the patient’s insurance.

   Transferring Facility

   Receiving Facility

   Print Name of Hospital Administrator or Designee ___________________________ Title of Hospital Administrator or Designee ___________________________ Date ______ Time ______

   Signature of Hospital Administrator or Designee ___________________________

   Print Name of Transferring Physician ___________________________ Title of Transferring Physician ___________________________ Date ______ Time ______

   Signature of Transferring Physician or Designee ___________________________

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   THIS IS A BINDING AGREEMENT. BREACH OF THIS AGREEMENT MAY IMPACT FUTURE TRANSFERS.