### SECTION I: DEMOGRAPHICS

1. **PATIENT’S NAME** (Last Name, First Name, Middle Initials)  
2. **PATIENT’S DATE OF BIRTH** (MM/DD/YYYY)

3. **PATIENT HAS AN ADVANCE DIRECTIVE**  
   - [ ] NO  
   - [ ] YES (send copy with patient)

4. **EMERGENCY CONTACT INFORMATION**
   
<table>
<thead>
<tr>
<th>NAME OF CONTACT</th>
<th>RELATIONSHIP</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

### SECTION II: REASON FOR TRANSFER

1. **NATURE OF SERVICES NEEDED BY PATIENT REQUIRING TRANSFER** (Select all that applies)
   - [ ] Diagnosis  
   - [ ] Consultation/Evaluation  
   - [ ] Return to healthcare facility
   - [ ] Treatment  
   - [ ] Service Not available at GMHA facility  
   - [ ] Other: (Specify)
   - [ ] Long Term Care  
   - [ ] No bed available at GMHA facility

2. **DESCRIBE SERVICES NEEDED**

### SECTION III. TYPE AND LEVEL OF SERVICES REQUIRED

1. **DIAGNOSIS**

2. **DESCRIPTION OF TREATMENT PRIOR TO TRANSFER**  
   - [ ] Refer to H&P and progress note

3. **DESCRIPTION OF FURTHER TREATMENT CONTEMPLATED**  
   - [ ] Refer to discharge summary

4. **LEVEL OF CARE PRIOR TO TRANSFER**
   - [ ] Emergency Department  
   - [ ] Intensive Care  
   - [ ] Telemetry  
   - [ ] Regular  
   - [ ] Long-Term (SNF)
   - [ ] Outpatient  
   - [ ] Other (Specify):
SECTION IV - CONDITION OF PATIENT ON TRANSFER

1. IS PATIENT MEDICALLY STABLE FOR TRANSFER  □ YES □ NO
Details

2. IS PATIENT BEHAVIORALLY STABLE FOR TRANSFER  □ YES □ NO
Details

SECTION V - MODE OF TRANSPORTATION

1. DESCRIBE SPECIAL MODE AND STAFF REQUIREMENTS
   STAFF ESCORT
   □ MD  □ RN  □ RRT

2. IV MEDICATION OR OTHER TREATMENT ENROUTE

SECTION VI - INFORMATION TO BE SENT WITH PATIENT

☐ Complete medical records  ☐ Discharge Summary  ☐ Transfer Note  ☐ ER Note
☐ Lab Results/Reports  ☐ Imaging studies report  ☐ ECG  ☐ Consent to Transfer
☐ Advance Directive  ☐ Other (Specify):

SECTION VII - PATIENT/FAMILY CONSENT RECEIVED (Must be completed for every transfer of UNSTABLE PATIENTS)

☐ PATIENT/FAMILY CONSENTS TO TRANSFER  REFERRING PHYSICIAN CERTIFIES THAT BENEFITS OF
(Send a copy with patient)  OUTWEIGHTS RISK

Physician's Signature  DATE  TIME

SECTION VIII - RESPONSIBLE INDIVIDUALS

1. NAME OF TRANSFERRING PHYSICIAN AT GMHA FACILITY

2. TRANSFERRING/ACCEPTING FACILITY

3. NAME OF ACCEPTING PHYSICIAN AT ACCEPTING FACILITY

4. TELEPHONE NUMBER

SECTION IX - DECISION

☐ NOT ACCEPTED (Specify Reason)  ☐ ACCEPTED, and
TRANSPORTATION AUTHORIZED

NAME OF WARD TO TRANSFER TO  DATE AND TIME OF TRANSFER

NAME OF PHYSICIAN COMPLETING THIS FORM  PHYSICIAN SIGNATURE  DATE AND TIME

INTERFACILITY TRANSFER NOTE
Guam Memorial Hospital Authority
Reviewed/Revised:
Stock #  Form #:  Page 2 of 2