UC San Diego Health

TRANSFER NOTIFICATION AND AGREEMENT

Patient Identification

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
   Transferring Facilty

   to and from_____ not covered by the patient's insurance.
   Receiving Facilty

_____ _____ _____ _____
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

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