Patient Transfer and Return Agreement

Patient Information Name: _____ Date of birth: _____

Any other name patient may be known by: _____ Diagnosis: _____

Reason for transfer: _____ Date of transfer: _____

Anticipated return date: _____ Payor*: _____ ID number*: _____

If newborn, please provide Mother's information:

Name: _____ Payor: _____ ID number: _____

Transferring Facility Information Facility: _____ Physician: _____

Patient account number*: _____ Contact name: _____

Contact title: _____ Contact phone number: _____

Authorization number for transfer to Children's: _____
(n/a for shared service transfers)

Authorization number for transport to Children's: _____
(if transport to be provided by Children's Transport Service)

**If shown on attached face sheet, this field does not need to be completed*

By the signature of the authorized representative below, _____, hereinafter referred to as the Transferring facility, hereby affirms and/or agrees that the following conditions are met:

1. The transfer is not based on financial criteria.
2. The patient, his or her designated representative or legal representative has given written informed consent for the transfer.
3. The patient is, to the best of the transferring facility's ability, medically stable for transport.
4. The transferring facility shall provide all pertinent medical information, including, but not limited to:
   - History of injury or illness
   - Patient condition, including vital signs and any other medical information as requested by the receiving facility or physician at Children's Healthcare of Atlanta
   - Name, address and telephone number of the physician at the Transferring facility

The Transferring Facility shall be responsible for arranging for the Patient's appropriate, safe transportation both to and, if applicable, from Children's Receiving Facility. Payment arrangements for the transport both to and, if applicable, from Children's Receiving Facility must be made by the Transferring Facility with no obligation on the part of Children's Healthcare of Atlanta. The Transferring Facility shall accept the Patient in return within twenty-four (24) hours of being notified that the determination has been made by the Patient's physicians at Children's Receiving Facility that the condition of the transferred Patient has stabilized and that the particular expertise initially prompting the transfer is no longer required.

For government payors that consider the services provided at Children's Receiving Facility to be services provided under arrangement or contractual shared services, the Transferring Facility agrees to reimburse Children's Receiving Facility for the care it provides to Patient based on Children's Receiving Facility's cost of care as defined by Georgia Medicaid on the date of Patient's admission to Children's Receiving Facility, or on the basis of an existing Transfer and Shared Services Agreement between Transferring Facility and Children's.

Transferring facility name: _____

Authorized hospital representative signature: _____

Please print name: _____

Title: _____

Date: _____

PLEASE RETURN COMPLETED FORM TO FAX NUMBER: 404-785-9186