



MEDICAL ALERT CENTER INPATIENT TRANSFER REQUEST FORM

Please fill out all requested information:

1. Include verification of Los Angeles County Resident (Valid CA License, DMV ID, Signed Affidavit, Current Utility Bill)
2. Demographic sheet
3. Do not send additional information unless requested. Allow 30-90 minutes before calling for a MAC number.

CONTACT THE MEDICAL ALERT CENTER IMMEDIATELY BY TELEPHONE FOR EMTALA OR EMERGENCY REQUEST AT (866) 940-4401 Option 1.

(Check one) New Request: _____ Update Previous Request: _____

Today's Date _____

To: Medical Alert Center

Telephone: (866) 940-4401 Fax: (562) 906-4300

Name of Sending Hospital: _____

Department: _____

Contact Person: _____ Title _____ Telephone # _____

Fax Number: _____ Number of Pages faxed: _____

County PF MR Number: _____ PTIS # (If Updating) _____

CHP # _____ CAPITATED TO: LAC/USC, HARBOR/UCLA, OLIVE VIEW M.C.

PT WILLING TO TRANSFER TO (circle as appropriate): LAC+USC, HARBOR - UCLA, OLIVE VIEW M.C.

LAST NAME	FIRST NAME	GENDER: M / F	DATE OF BIRTH	AGE
SSN	PAYMENT SOURCE (Self, CHP, In Custody)		ADMIT DATE	
ATTENDING M.D.	DIRECT M.D. CONTACT NUMBER		SPECIALTY	
ALTERNATE M.D.	DIRECT M.D. CONTACT NUMBER		SPECIALTY	
TYPE OF BED (WARD, TELE, ICU, ISO, JAIL, STEP DOWN)	NURSING STATION TELEPHONE		PT LOCATION (FLOOR/BED)	
PRIMARY SERVICE	TRANSFERRING DIAGNOSIS		SECONDARY SERVICES NEEDED	
REASON FOR TRANSFER OR HIGHER LEVEL OF CARE				

PATIENT'S NAME: _____

TODAY'S DATE: _____

CHIEF COMPLAINT/INITIAL PRESENTATION

PHYSICAL EXAM

GEN	
HEENT	
CHEST	
ABD	
EXT	
PAST MEDICAL /SURGICAL HISTORY	

VITAL SIGNS

DATE	TIME	BP	PULSE	RESP	TEMP	SpO2	O2 L/m

DEFINITIVE DIAGNOSIS

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TREATMENT PLAN

PROCEDURES/TREATMENT NEEDED	PROCEDURES DONE

MEDICATIONS/IV FLUIDS

PATIENT'S NAME: _____

TODAY'S DATE: _____

IMAGING/DIAGNOSTIC TESTING

STUDY	DATE	IMPRESSION/FINDING/RESULT

LABS

BLOOD CULTURE RESULT:

--

CBC W/DIFF:

DATE	TIME	WBC	HGB	HCT	PLT	SEGS	BANDS	BASO	EOS	LYMPH	MONO

CHEMISTRY PANEL:

DATE	TIME	NA	K	CL	CO2	BUN	CR	GLU	CA

GUIAC: POSITIVE/NEGATIVE QUAL HCG: POSITIVE/NEG

CARDIAC ENZYMES:

DATE	TIME	CK	CK/MB	TROPONIN

LIVER FUNCTION TEST:

DATE	TIME	AST	ALT	ALK/PHOS	TBILI	DBILI	LIPASE	AMYLASE

ARTERIAL BLOOD GAS:

DATE	TIME	PH	PCO2	PO2	HCO3	B.E.	SAO2	COHB

U/A:

DATE	TIME	SG	PH	WBC	RBC	BACT	PROTEIN	KETONE	GLU

COAGS:

DATE	TIME	PT	PTT	INR