RESET FORM

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) 378-1000

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: 0, 0_____ **TODAY'S DATE:** _____

CHIEF COMPLAINT/INITIAL PRESENTATION

PHYSICAL EXAM

GEN	
HEENT	
CHEST	
ABD	
EXT	
PAST MEDICAL /SURGICAL HISTORY	

VITAL SIGNS

DATE	TIME	BP	PUSE	RESP	TEMP	SpO2	O2 L/m

DEFINITIVE DIAGNOSIS

TREATMENT PLAN

PROCEDURES/TREATMENT NEEDED	PROCEDURES DONE

MEDICATIONS/IV FLUIDS

PATIENT'S NAME: 0, 0 **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	PC02	PO2	HCO3	B.E.	SAO2	COHB

U/A:

DATE	TIME	SG	PH	WBC	RBC	BACT	PROTEIN	KETONE	GLU

COAGS:

DATE	TIME	PT	PTT	INR