Patient Identification Label

PATIENT EXTERNAL TRANSFER CONSENT FORM

I, _____ understand that the ABC Hospital intends to transfer me/ my _____ to _____ for further care. I have been informed that the reason for transfer is as follows:

_____

_____

_____

I have been informed of the following associated risks and/ or benefits of this transfer;

_____

_____

_____

The above information has been fully explained to me and I agree to be transferred.

Patient Signature: _____

Witness: _____

Or

Name of the Guardian: _____

Signature of the Guardian: _____

Relationship: _____

Date: _____

Physician Name: _____ Signature: _____

Date & Time: _____