Regional Medical Center

Dear Patient:

Our goal is to provide you with the best care possible. Your doctor has ordered a transfer for you to a skilled, sub-acute or rehab facility, for your continued recovery. You have the right to choose the facility to provide these services.

Your Care Coordinator will notify you if the insurance you carry requires a specific facility. If you choose not to use the facility your insurance company requires, you may be responsible for all or part of the charges.

Below you will find facilities who provide this care. Peninsula Regional Medical Center has a financial interest in the Peninsula Transitional Care Unit and Salisbury Rehab and Nursing Center.

☐ Transitional Care Unit at Peninsula Regional Medical Center

☐ Salisbury Rehab and Nursing Center

☐ Anchorage Nursing and Rehabilitation Center
☐ Arcadia Nursing Home
☐ Berlin Nursing Home
☐ Chancellor Care Nursing Center
☐ Deer's Head Center
☐ HealthSouth – Chesapeake Rehab
☐ Hartley Hall Nursing Home
☐ Other : _____

_____

☐ I have no preference.

☐ Life Care at Lofland Park
☐ Mallard Bay Nursing Center
☐ Manokin Nursing Home
☐ Ruxton Health of Denton
☐ Shore Life Care
☐ Snow Hill Nursing Home
☐ Wicomico Nursing Home

NOTE: Providing this information does not constitute an endorsement.

I have indicated the agency I wish to use with an "X" mark.
By signing this form I am giving permission for the above selected agency to access information from my medical record which may be deemed necessary for my care.

_____ _____
PATIENT/DESIGNEE SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

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SS-014 (6/05)

REGIONAL MEDICAL CENTER

CONSENT TO TRANSFER TO ANOTHER FACILITY

SECTION I: Use Section I for patients transferring to a Nursing Home or Rehabilitation Facility.

I/We understand that in the opinion of _____ (attending physician),

_____ (patient name) would receive [appropriate or desired] continuing care at

_____ (receiving facility) under the care of

_____ (receiving M.D.) due to _____ (medical condition/injury/[patient request])

_____

_____

Therefore, I/we agree to be transported/transfer the person named above by _____

_____ (name of transporter) from Peninsula Regional Medical Center to

_____ (address of receiving facility)

I/We understand financial accountability will be mine/ours for services rendered by the transporting provider. I/we further release Dr._____ and Peninsula Regional Medical Center from damages resulting from any financial obligations incurred as a result of this transfer. I/we acknowledge, I/we understand the necessity for transfer and associated risks with such.

_____ _____

Patient or Closest Relative / Legal Gaurdian **Date** **Witness**

SECTION II: Use Section II for patients transferring to an Acute Care Facility.

TRANSFER CERTIFICATION:

Based on the information available at this time, as reflected in the summary below, I hereby certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at the below named facility outweigh the increased risks, if any, to the individual and, in the case of labor, to the unborn, which may arise from effecting the transfer. I have explained the risk and benefits of this transfer and the necessary continuance of treatment to the patient (and his/her representatives).

Name of accepting Facility_____

SUMMARY

Benefits	**Risks**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Physician Signature **Date** **Witness**

I/we understand the financial accountability will be mine/ours for services rendered by the transporting provider. I/we further release the above named physician and Peninsula Regional from damages resulting from any financial obligations incurred as a result of this transfer. I/we acknowledge I/we understand the necessity for transfer and associated risks with such. I/we authorize Peninsula Regional to furnish copies of my medical records to above receiving facility. I have been further informed by the above named physician of all the risks and benefits of examination/treatment associated with transfer to another facility. I do hereby request/refuse (circle one) transfer for further treatment of my condition.

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_____ _____

Patient or Closest Relative / Legal Gaurdian **Date** **Witness**