

PLACE PATIENT
ID LABELS INSIDE BOX



DT70080

Consent to Transport and Care

1. DIAGNOSIS AND NEED FOR TRANSPORT

The diagnosis of _____ is _____ which means
Patient Medical Terms

in Terms Understandable to the Parents

I understand that Doctor _____ recommends transfer of the child
Patient's Physician
to _____ for further diagnosis, treatment and care.
Hospital

2. RISKS OF TRANSPORTATION

I understand that the risks which can be reasonably anticipated by transfer of the child include:

- The general risks associated with medical transports include possible medical equipment, aircraft, or vehicle failure; traffic hazards; adverse weather conditions; pilot or driver error; interruption of medical treatment during transport; or consequences of actions of persons outside the control of transport personnel.
- Risks associated with all medical transports because of the child's condition. These include the possible worsening of the child's condition during transport or inability to fully treat or diagnose due to the unavailability of more sophisticated medical equipment and facilities not normally available during transports.
- Other inherent risks, if any, anticipated by reason of this child's particular condition are: _____

3. CONSENT TO TRANSPORT AND CARE

I consider the above risks of transport are outweighed by the advantage of care in the receiving hospital and therefore **consent to Rady Children's Hospital Emergency Transport providing transportation and necessary care to the above child.**

4. AUTHORIZATION FOR ADMISSION

Understanding the above child's condition, I accept the opinion of the above physician and referral hospital and that this condition justifies admission to the above hospital and agree to the performance of any emergency medical or surgical procedures which are deemed necessary for the above child.

5. RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, the Hospital may disclose portions of the patient's financial and medical records to any person or corporation or to any agent of any such person or corporation which is or may be liable for all or any portion of the Hospital's charges, including but not limited to insurance companies, employers, health care service plans or workers compensation carriers. The Hospital may also make available pertinent information to government social agencies and other health care providers as necessary to insure continuity of care and availability of health care services for the patient's family.

6. STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that there is no commitment or guarantee of financial assistance from any third party and that I am financially responsible for all charges and expenses incurred.

7. AUTHORIZATION TO PAY INSURANCE BENEFITS

I authorize payment directly to the hospital and all physicians for fees incurred which relate to this period of emergency care, transportation and hospitalization.

8. PARENT / LEGAL GUARDIAN STATEMENT

I understand the content of this form and have been notified of the diagnosis and risks of transport. I acknowledge and consent to the provision of care for the above child, as outlined by this consent.

Su firma indica que leyó el reverso de esta hoja y consiente al transporte del paciente.

Date (Fecha)

Time (Hora)

Parent of Legal Guardian (Padre / Guardian Legal)

Witness (Testigo)

2nd Witness - For Verbal Consent Only (Segundo Testigo - Solamente Para Consentimiento Oral)

9. PHYSICIAN / NURSE CLINICIAN

Date (Fecha)

Physician or Nurse Clinician (Doctor o Enfermera)

I have accurately and completely read the foregoing document to _____
Name

in _____, the patient's / legal representative's primary language. He/she stated
Identify Language

he/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

Date (Fecha)

Name / Title of Translator