Non-EMTALA Request for Transfer to Cedars-Sinai Inpatient

Complete the information below and fax to 310-423-3305 with face sheet; front and back of insurance card, and authorization to transfer (as applicable). You will be contacted by the Transfer Center for next steps or additional information.

Patient Name _____ Date of Birth _____ Sex ☐ Male ☐ Female ☐ Other _____

Name of Facility Requesting Transfer _____

Name of Person Submitting Request _____ Title of Person Submitting Request _____ Phone _____

Patient Room Number & Unit _____ Name of Patient Nurse _____ Phone _____

Provide patient diagnosis and clinical care needs

_____

_____

_____

_____

Why is transfer to Cedars-Sinai being requested?

- ☐ Service not available/ unable to provide care
- ☐ Cedars physician request
- ☐ Sending facility physician
- ☐ Patient preference
- ☐ Insurance/contracted facility
- ☐ Resource/capacity management

Is the patient aware and agrees to the plan of care? ☐ Yes ☐ No

Does the patient already have an accepting physician at CSMC? ☐ Yes ☐ No

_____

Physician Name

What are the ongoing needs of the patient (i.e. surgeries, procedures)?

_____

_____

_____

If patient coming for care not offered at your facility, is the patient willing to return to your facility after treatment?

☐ Yes ☐ No

Are there any special medications needed by the patient? ☐ Yes ☐ No

Please specify. (include chemotherapy)

_____

_____

Funding Source (please attach front and back copies of insurance card): ☐ Insurance ☐ Self Pay

Insurance Carrier _____ Phone _____ Subscriber ID _____

Insurance Case Manager _____ Phone _____ Fax _____

Approved for transfer to Cedars-Sinai? (if provided, attached insurance authorization to transfer) ☐ Yes ☐ No

_____

Transfer authorization #