PATIENT TRANSFER REPORTING FORM

(Pursuant to Business and Professions Code Section 2240)

Part A					
1. Name of Patient's Physician in the Outpatient Setting					
Last		First		Middle	
License Number:					
2. Name of Physician with Hospital Privileges (if the same as above, leave blank)					
Last		First		Middle	
License Number:					
3. Name of Hospital or Emergency Center Where Patient was transferred					
Address:					
4. Patient Information					
Last Name		First Name		Middle	
Address					
4b Patient Identifier (enter one of the following)					
Medical Record Number		Social Security Number		Patient ID Number	
Other:					

Date of Report: _____

State law (Business and Professions Code Section 2240[b]) requires that a completed copy of this entire form (Part A and Part B) be placed in the patient's file.

After completing the form:

- Send one copy of the full form to the facility identified in #3 above for insertion in the patient's record.
- Send one copy of Part B only within 15 days of the transfer to the Office of Statewide Health Planning and Development.

Provision of additional patient level information that is not required by law may be a violation of HIPAA.

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State law (Business and Professions Code Section 2240) requires that only part B of the reporting form shall be filed with the Office of Statewide Health Planning and Development.

Part B

1. Type of outpatient procedure performed : – ☑ check appropriate box

- ☐ Cosmetic
- ☐ Gastrointestinal
- ☐ General Surgical
- ☐ Gynecological
- ☐ Ophthalmological
- ☐ Orthopedic
- ☐ Otolaryngology/ENT
- ☐ Pain Management
- ☐ Urological
- ☐ Other/Misc

2. Events triggering transfer – ☑ check all appropriate boxes

- ☐ Transfer was planned prior to procedure
- ☐ Aspiration
- ☐ Cardiovascular Distress
- ☐ Drug Reaction
- ☐ Excessive Bleeding
- ☐ Pain Management
- ☐ Perforation/Surgical Complication
- ☐ Post-op care/observation needed
- ☐ Procedure converted to open
- ☐ Respiratory Distress
- ☐ Other

3. Duration of Hospital Stay – ☑ check appropriate box (as of the date of this report)

- ☐ Less than 24 hours*
- ☐ 24-72 hours
- ☐ 4-7 days
- ☐ 8-14 days
- ☐ Over 14 days

4. Final Disposition or status, if not released from the hospital, of the patient – ☑ check appropriate box

- ☐ Patient sent home
- ☐ Patient still in hospital
- ☐ Patient transferred to SNF/Rehab. facility
- ☐ Patient died
- ☐ Other

5. Physician's Practice Specialty and ABMS Certification, if applicable

(Do not include License # or other personally identifiable information)

*State law only requires that transfers to a hospital or emergency room for medical treatment exceeding 24 hours must be reported.

NOTE: Please do not provide any other patient information on this portion of the form. Provision of additional patient level information that is not required by law may be a violation of HIPAA.

Part B shall be mailed within 15 days of the transfer to:

Office of Statewide Health Planning and Development
Patient Data Section
Attn.: Physician Reporting – Transfers
400 R Street, Suite 270
Sacramento, CA 95811