FORM 9-7

Patient Transfer Acknowledgment

Re: Transfer of ____
(patient name)

I understand that I have a right to receive medical screening, examination, and evaluation by a physician (or other appropriate personnel), without regard to my ability to pay, prior to any transfer from this hospital. I also have a right to be informed of the reasons for any transfer. I acknowledge that I have received medical screening, examination, and evaluation by a physician (or other appropriate personnel), and that I have been informed of the reasons for my transfer.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: ______________________ Time: ______________________ AM / PM

Signature: ____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: ______________________

Print name: ____
(legal representative)

Should you have any complaints concerning the services you have received from this hospital, you may contact:

Department of Public Health, Licensing and Certification

______________________________ *District Office

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COPY MUST BE SENT WITH PATIENT.

**Fill in the name, address and telephone number of the appropriate CDPH district office.*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1317.3(d)

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FORM 9-7S

Reconocimiento de Traslado por Parte del Paciente

Asunto: Traslado de ____
(nombre del paciente)

Entiendo que tengo el derecho a recibir un diagnóstico inicial, examen y evaluación médica de parte de un médico u otro miembro capacitado del personal, independientemente de mi habilidad de pagar, antes de ser trasladado de este hospital y que tengo el derecho a que se me informe de los motivos de cualquier traslado. También tengo el derecho de que se me informen los motivos de todo traslado. Reconozco que he recibido un diagnóstico inicial, examen y evaluación médicos de parte de un médico u otro miembro capacitado del personal y que se me ha informado de las razones de mi traslado.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: ______________________________ Hora: ____________________ AM / PM

Firma: ____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: ______________________

Nombre en letra de imprenta: ______________________________________
(representante legal)

Si tiene usted cualquier queja respecto a los servicios que ha recibido de este hospital, puede ponerse en contacto con:

Departamento de Salud Pública de California, Certificación y Licencias

______________________________________ *Oficina de Destrito

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COPY MUST BE SENT WITH PATIENT.

**Fill in the name, address and telephone number of the appropriate CDPH district office.*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1317.3(d)