

# Inter-Facility Medical Transfer Request Form

Patient Name

Date of Birth

Patient ID / MRN

Diagnosis / Reason for Transfer

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## Transferring Facility

Facility Name

Phone

Requesting Physician

Contact Person

## Receiving Facility

Facility Name

Phone

Accepting Physician

Contact Person

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Requested Transfer Date

Time

Mode of Transport

Level of Care Required

Other Requirements

Form Completed By

Date