Huntington Hospital

Inter-hospital Transfer/Direct Admit Request Form

Please print legible in dark ink

Date: _____

Requesting hospital/physician: _____ HH MRN: _____

Patient's Last Name: _____ Patient's First Name: _____

Patient's DOB: _____ Age: _____ Gender: M / F

Admission Date: _____ Diagnosis: _____

Contact Person: _____ Phone #: _____

Fax #: _____

Requested Level of Care: □CCU □DOU □ Telemetry □Med/surg-non tele □Other: _____

Transferring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone #: _____

Reason for Transfer: □Higher Level of Care □Patient/Family Request □Other: _____

Procedure or specialty needed: _____

Insurance: □ Medicare □ Medi-Cal □ PPO □ HMO/IPA: _____

Is transfer authorized by insurance? □No □Yes □Pending Authorization #: _____

Insurance contact: _____ Title: _____ Phone #: _____

Huntington Hospital

Accepting Physician: _____ Phone #: _____

Has physician confirmed they will accept? □No □Yes

Has specialist/surgeon been contacted? □No □Yes By: _____

Specialist/ surgeon: _____ Phone #: _____

HH Contact: _____ Phone #: (626)_____

Fax #: (626)_____

Notes to physician: