



POLICY NO:	FAC 4
DATE ISSUED:	Apr. 2021

EMERGENCY DEPARTMENT INTERFACILITY TRANSFERS

I. PURPOSE

This policy provides guidance for emergency departments for ground ambulance transport of emergency patients that require interfacility transfer at the Basic (EMT), Advanced Life Support (Paramedic), or Critical Care Transport (CCT) levels.

II. AUTHORITY

California Code of Regulations, Title 22, Division 9, §100128 and §100170

III. POLICY

- A. All transfers shall comply with State and Federal laws.
- B. The sending Emergency Department (“ED”) physician is responsible for determining the appropriate level of transport required.
- C. The sending physician is responsible for making arrangements for the receipt of the patient by another physician at the receiving facility.
- D. The sending physician or designee shall contact the appropriate dispatch center to arrange for transport.
- E. The sending physician or designee shall provide a verbal report and transfer documents to the arriving ambulance crew. Transfer documents must include the names of the sending and receiving physician.
- F. For patients who requires emergency transfer, specifically those needing immediate care or intervention at a higher level of care receiving hospital (e.g., critical trauma, STEMI or stroke):
 - 1. Ensure the indication for use is appropriate. Emergency ambulance transport utilizes 9-1-1 resources and is reserved for truly emergent cases;
 - 2. Activate 9-1-1 to request Interfacility Emergency Response;
 - 3. Arrange transfer of the patient with the receiving physician;
 - 4. Assess patient needs during transport to determine if the patient needs exceed the paramedic scope of practice. If the care required during transport is beyond the

paramedic scope of practice, hospital staff and/or equipment shall be provided by the transferring hospital and accompany patient (e.g., if IV pump needed, blood transfusion in progress, management of paralytic agents for intubated patient);

5. Prepared transfer records for the arriving ambulance crew. The ambulance will generally arrive within twelve (12) minutes of request and patient, paperwork, staff and equipment should be ready for transport by the time the ambulance arrives. If the transferred is delayed once the ambulance arrives on scene, the 9-1-1 ambulance may be reassigned for other emergency needs. If additional records are not available, they can be faxed or transported separately.

IV. LEVELS OF CARE FOR AMBULANCE TRANSPORT

Type of Transport	Patient Needs	Scope of Practice	Contact
9-1-1 Advanced Life Support (Paramedic) Interfacility Emergency Transfer	Emergency intervention or evaluation not available at the sending hospital (e.g., critical trauma, STEMI, stroke, obstetric care for active labor where birth is not imminent). May include neuro and vascular patients transported directly to an OR/intervention lab.	<ol style="list-style-type: none"> 1. Advanced airway (ETT and King); 2. Administer and adjust IV fluids including: Glucose, isotonic saline, lactated ringers, and those containing potassium; 3. ECG monitoring; 4. Defibrillation and synchronized cardioversion; 5. Monitoring of water-sealed chest tube; 6. Administration of ACLS medications 	9-1-1
Type of Transport	Patient Needs	Scope of Practice	Contact
Critical Care Transport with RN	Advanced care for patients with complex medical care needs as determined by the transferring physician and the ambulance agency. May include pediatric and obstetric patients.	Critical Care RN	Contact ambulance service directly
Air Ambulance	RN/Paramedic level of care for patients with complex medical care needs when the receiving hospital is distant and time is a critical factor. May include pediatric and obstetric patients.	Critical Care RN/Paramedic	Contact air ambulance service directly

Type of Transport	Patient Needs	Scope of Practice	Contact
Non-emergency Advanced Life Support (Paramedic)	Scheduled transport of patients who require an advanced level of care. Patient does not require emergency intervention at the receiving facility.	<ol style="list-style-type: none"> 1. Advanced airway (ETT and King); 2. Administer and adjust IV fluids including: Glucose, isotonic saline, lactated ringers, and those containing potassium; 3. ECG monitoring; 4. Defibrillation and synchronized cardioversion; 5. Monitoring of water-sealed chest tube; 6. Administration of ACLS medications 	Contact ambulance service directly
Non-emergency Basic Life Support (EMT)	Scheduled transport of patients who require a basic level of care.	EMT	Contact ambulance service directly

V. TRAUMA TRANSFER PROCEDURE

TRAUMA TRANSFER PROCEDURE

STEP 1	Determine appropriate level of transfer using chart below. Contact receiving Trauma Center and confirm acceptance of the patient Stanford Trauma Center 1. 1-650-723-7337 (Emergency Adult & Peds) 2. 1-800-800-1551 (Urgent Adult & Peds) Zuckerberg S.F. General Trauma Center: 1-628-206-8111 **Request to speak to Attending in Charge ("AIC") about Trauma Re-Triage Patient**
STEP 2	As soon as need for transfer is recognized, request CODE 3 TRAUMA TRANSFER by calling 9-1-1.
STEP 3	Prepare patient and paperwork for immediate transport before ambulance arrives.
STEP 4	For consults for patients not meeting red or blue box criteria, contact the trauma center and request to speak to the Trauma AIC about Trauma Re-Triage Patient

TRAUMA TRANSPORTATION SELECTION CRITERIA

EMERGENCY TRANSFER PATIENTS: Call Trauma Center PRIOR to Transfer and state RED BOX TRAUMA TRANSFER

ED physician determines patient requires immediate evaluation/resuscitation by a trauma center

May include:

1. Hemodynamically unstable
 - a. B/P of < 90 or
 - b. Decrease in B/P by 30mmHg following 2 liters of IV crystalloid
2. Head Injury with Blown Pupil
3. Penetrating head, thoracic or abdominal Trauma

URGENT TRANSFER PATIENTS: Call Trauma Center PRIOR to Transfer

ED physician determines that the patient requires urgent evaluation by a trauma center based on the following indicators:

Anatomic area	Related Injuries
Central Nervous System	<ul style="list-style-type: none"> • GCS < 14 with abnormal CT Scan • Spinal Cord or major vertebral injury
Chest	<ul style="list-style-type: none"> • Major chest wall injury with >3 rib fractures and/or pulmonary contusion • Cardiac Injury
Pelvis/Abdomen	<ul style="list-style-type: none"> • Pelvic ring disruption • Solid organ injury confirmed by CT Scan or ultrasound demonstrating abdominal fluid
Major extremity injuries	<ul style="list-style-type: none"> • Fracture/dislocation with loss of distal pulses and/or ischemia • Open long bone fractures • Two or more long bone fractures • Amputations that require reimplantation
Co-morbid factors	<ul style="list-style-type: none"> • Adults > 65 y/o • Pediatric < 6 y/o Transfer to Stanford (Pediatric Trauma Center) • Pregnancy - >22 weeks gestation • Insulin dependent diabetes • Morbid obesity • Cardiac or Respiratory disease • Immunosuppression • Antiplatelet or anticoagulation agents
Multiple-System Injury	<ul style="list-style-type: none"> • Trauma with associated burns Transfer to closest Trauma Center • Major injury to more than two body regions • Signs of hypoperfusion – Lactate >4 or Base Deficit >4