### EMS Transfer of Care Form

**Patient Name**

**Patient Next of Kin Name / Phone**

**Address** /  

**EMS Agency Name / Affiliate Number**

**City**

**State**

**Zip**

**Date**

**Time**

**Incident Number**

**Age**

**Gender (M / F)**

**Date of Birth**

**SSN**

**Incident Location:**

**Chief Complaint / Provider Impression:**

### BRIEF HISTORY / PERTINENT SYMPTOMS

**For Stroke, Chest Pain, Trauma or Altered Mental Status**

**Time of Persistent Symptoms, Injury, or Last Seen Normal**

**Date**

**Time**

**EMS Contact Time – First EMS**

**ALS Contact Time**

### PERTINENT PHYSICAL EXAM FINDINGS

### MEDICATIONS

[ ] NONE

**Patient Medications or Medication List Delivered with Report**

[ ] Yes

### ALLERGIES

[ ] NKDA

**Patient Medications or Medication List Delivered with Report**

[ ] Yes

### VITAL SIGNS

<table>
<thead>
<tr>
<th>Time</th>
<th>Pulse</th>
<th>Blood Pressure</th>
<th>Resp</th>
<th>Glucose</th>
<th>SaO2</th>
<th>Mental Status (AVPU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>Voice</td>
<td>Pain</td>
<td>Unresponsive</td>
<td></td>
<td></td>
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</tbody>
</table>

### ECG

**Rhythm:**

12-lead ECG Interpretation:

**Copy of Rhythm Strip/ all 12-lead ECGs Delivered with Report**

[ ] Yes

### EMS TREATMENT

**Time**

**Medication/ Intervention**

**Dose**

**IV**

[ ] Yes

[ ] No

**IV Fluid Type:**

**Size/Location:**

**Total IV Fluid Volume given:**

**mL**

**Oxygen:**

**LPM**

### PROVIDER TRANSFERRING CARE

**QRS Provider**

**QRS Provider Signature:**

**EMS Provider**

**EMS Provider Signature:**

**Signature:** ____________________________(Print) ____________________________

### CARE TRANSFERRED TO

**Receiving Hospital/Agency Name:**

**Time of Transfer**

**Receiving Healthcare Provider Signature:**

**Signature:** ____________________________(Print) ____________________________

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**Bureau of Emergency Medical Services**

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