pennsylvania
DEPARTMENT OF HEALTH

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

ALLERGIES

☐ **NKDA**

MEDICATIONS

☐ NONE

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

VITAL SIGNS

Time	Pulse	Blood Pressure	Resp	Glucose	SaO2	Mental Status (AVPU)			
		/				☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
		/				☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
		/				☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive

ECG

Rhythm:	**12-lead ECG Interpretation**:	**Copy of Rhythm Strip/ all 12-lead ECGs Delivered with Report** ☐ Yes

EMS TREATMENT

Time	Medication/ Intervention	Dose

NOTES / COMMENTS

IV ☐ Yes ☐ No	**IV Fluid Type**:	**Size/Location**:	**Total IV Fluid Volume Given:** mL	Oxygen: LPM

PROVIDER TRANSFERRING CARE	**CERTIFICATION NUMBER**	**CARE TRANSFERRED TO**	
QRS Provider		**Receiving Hospital/Agency Name**:	**Time of Transfer**
QRS Provider Signature:			
EMS Provider		**Receiving Healthcare Provider Signature:**	
EMS Provider Signature:		Signature:_____ (Print) _____	