pennsylvania
DEPARTMENT OF HEALTH

EMS Transfer Of Care Form

Patient Name						
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

QRS Provider	**CERTIFICATION NUMBER**
QRS Provider Signature:	
EMS Provider	
EMS Provider Signature:	

CARE TRANSFERRED TO

Receiving Hospital/Agency Name:

Time of Transfer

Receiving Healthcare Provider Signature:

Signature:_____ (Print) _____