pennsylvania
DEPARTMENT OF HEALTH

# *EMS TRANSFER OF CARE FORM*

| Date: | EMS Agency |
|---|---|
| | |

| Patient Name: | Date of Birth | Age | Male | Female |
|---|---|---|---|---|
| | | | | |

| Chief Complaint: | For STEMI / Stroke | | |
|---|---|---|---|
| | Onset of Persistent Symptoms or Last Seen Normal | Date | Time |

Symptoms/Brief History

| Allergies | |
|---|---|
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| | |
| No Known Drug Allergies | Yes |

Continue Lists on Back if Needed

| Medications: | | |
|---|---|---|
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| | | |
| Patient Medications or Medication List Delivered with Report | | Yes |

| VITAL SIGNS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time | Pulse | Blood Pressure | | Resp | Glucose | SaO2 | Mental Status (AVPU) | | | |
| | | | | | | | Alert | Responds to Voice | Responds to Pain | Unresponsive |
| | | | | | | | | | | |
| | | | | | | | | | | |
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| Suspected Injuries / Illnesses | | |
|---|---|---|
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| | | |

| EMS Treatment | | | | | | |
|---|---|---|---|---|---|---|
| Time | | Medication | | Dose | NOTES / COMMENTS | |
| | | | | | | |
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| | | | | | 12-Lead ECG Delivered With Report (Copy of each ECG REQUIRED) | Yes |
| IV | Yes | Fluid Type: | | Total IV Fluid Volume Given: | mL | |

| EMS Provider Transferring Care | Certification Number | Care Transferred To: | | |
|---|---|---|---|---|
| | | (Another) EMS Agency/Service Name: | Date | Time |
| | | Receiving Facility (Hospital) Name: | Date | Time |

| Provider Signature: | Receiving Facility RN / PA / MD / DO Signature: |
|---|---|
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