EMS Transfer Of Care Form

Run Number			
Date		Time	
Date of Birth		Age (Years)	M ☐ F ☐
Phone Number			

Patient Name		

Chief Complaint

Patient Contact Time	

For STEMI / Stroke		
	Date	Time
Onset of Persistent Symptoms or Last Seen Normal		

History of Present Illness

Pertinent Physical Exam Findings

Allergies	
☐ NKDA	
☐ PCN	
☐ Sulfa	
☐ Latex	
☐ IVP Dye	

Current Medications				
Common	Name	Dose	Name	Dose
☐ None				
☐ Albuterol				
☐ ASA				
☐ NTG				

Past Medical History					
☐ Alcohol Abuse	☐ Cancer	☐ Diabetes	☐ Myocardial Infarction		
☐ Asthma	☐ CHF	☐ ESRD	☐ None		
☐ Atrial Fib	☐ COPD	☐ GI Bleed	☐ Psychiatric		
☐ CABG	☐ CVA/TIA	☐ High Cholesterol	☐ Seizures/Convulsions		
☐ CAD	☐ Dementia	☐ Hypertension	☐ Substance Abuse		

VITAL SIGNS

Time	Pulse	Blood Pressure	Resp	SaO2	Glucose	Rhythm	Pain	GCS E	GCS V	GCS M	Comments
		/		☐ RA							
		/		☐ RA							
		/		☐ RA							

EMS Treatment

Time	PROC	Action/Meds	Dose/Size	HR	BP	SaO2	EtCO2	Resp	RE	Rhythm	Pain	GCS
					/							
					/							
					/							
					/							
					/							
					/							

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

Provider Signature:

Receiving Facility RN / PA / MD / DO Signature:

Signature: ____________________ Print: ____________________