



EMS Transfer Of Care Form

Patient Name			
Address			
City		State	Zip
Date	Time	Incident Number	Age
Gender (M / F)		Date of Birth	SSN

EMS Agency Name / Affiliate Number

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)			
						<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
						<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
						<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive

ECG

Rhythm: _____ 12-lead ECG Interpretation: _____

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

EMS TREATMENT			NOTES / COMMENTS
Time	Medication/ Intervention	Dose	

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:		Receiving Healthcare Provider Signature:	
EMS Provider		Signature: _____ (Print) _____	
EMS Provider signature:			