



EMS Transfer Of Care Form

Patient Name		Run Number		
Chief Complaint		Date	Time	
History of Present Illness		Date of Birth	Age (Years)	M <input type="checkbox"/> F <input type="checkbox"/>
Pertinent Physical Exam Findings		Phone Number		
		Patient Contact Time	For STEMI / Stroke	
		Onset of Persistent Symptoms or Last Seen Normal	Date	Time

Allergies
<input type="checkbox"/> NKDA <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa <input type="checkbox"/> Latex <input type="checkbox"/> IVP Dye

Current Medications			
Common	Name	Dose	Name
<input type="checkbox"/> None <input type="checkbox"/> Albuterol <input type="checkbox"/> ASA <input type="checkbox"/> NTG			

Past Medical History			
<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fib <input type="checkbox"/> CABG <input type="checkbox"/> CAD	<input type="checkbox"/> Cancer <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> CVA/TIA <input type="checkbox"/> Dementia	<input type="checkbox"/> Diabetes <input type="checkbox"/> ESRD <input type="checkbox"/> GI Bleed <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypertension	<input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> None <input type="checkbox"/> Psychiatric <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Substance Abuse

VITAL SIGNS										
Time	Pulse	Blood Pressure	Resp	SaO2	Glucose	Rhythm	Pain	GCS		Comments
								E	V	
		/		<input type="checkbox"/> RA						
		/		<input type="checkbox"/> RA						
		/		<input type="checkbox"/> RA						

EMS Treatment												
Time	PROC	Action/Meds	Dose/Size	HR	BP	SaO2	EtCO2	Resp	RE	Rhythm	Pain	GCS
					/							
					/							
					/							
					/							
					/							
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EMS Provider Transferring Care	Certification Number	Care Transferred To:		
D <input type="checkbox"/> P <input type="checkbox"/> <hr/> D <input type="checkbox"/> P <input type="checkbox"/>		(Another EMS Agency / Service Name:	Date	Time
		Receiving Facility (Hospital) Name:	Date	Time
Provider Signature:		Receiving Facility RN / PA / MD / DO Signature:		
		Signature: _____	Print: _____	