pennsylvania
DEPARTMENT OF HEALTH

EMS Transfer Of Care Form

EMS Agency Name / Affiliate Number			Patient Name Address 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	CERTIFICATION NUMBER	CARE TRANSFERRED TO	
QRS Provider		Receiving Hospital/Agency Name:	Time of Transfer
QRS Provider Signature:			
EMS Provider		Receiving Healthcare Provider Signature:	
EMS Provider Signature:		Signature:_____ (Print) _____	