EMS Information Bulletin 2012-009

DATE: August 1, 2012

SUBJECT: EMS Transfer of Care Reporting Form

TO: Regional EMS Councils and EMS Agencies

FROM: Bureau of Emergency Medical Services
PA Department of Health
(717) 787-8740

The process of hand-off of care between EMS providers has been identified as a time when patients are susceptible to medical errors. In addition to the important verbal report and the opportunity for the receiving provider to ask questions and clarify the report, it is critical to provide a written report of the minimal information that is critical to safe patient care at the receiving facility.

The Bureau of EMS has been piloting a standardized EMS Transfer of Care form for the purpose of documenting critical information for the receiving facility. The second version of this form (“DRAFT V2 8-1-12”) and its accompanying instructions are attachments to this EMS Information Bulletin.

The BEMS encourages all interested EMS agencies and receiving facilities to participate in the pilot use of this form. We are interested in developing the best possible form for future use, and therefore we hope that each agency and receiving facility that gains experience with this version of the pilot form will provide specific feedback to the BEMS. Please send your comments to:

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625 Forster Street
Harrisburg, PA 17120-0701
paemsoffice@state.pa.us
# EMS Transfer Of Care Form

**Date:**

**Time:**

**EMS Agency Name:**

**Patient Name:**

**Phone #:**

**Date of Birth:**

**Age:**

- [ ] Male
- [ ] Female

**Chief Complaint:**

**Provider Impression:**

## History / Exam

**Symptoms/Brief History (Sample):**

**For Altered Mental Status, Chest pain, or Stroke**

**Onset of Persistent Symptoms / Last Seen Normal**

- **Date:**
- **Time:**

- [ ] Diabetes
- [ ] HTN
- [ ] Heart Problems
- [ ] Cancer
- [ ] Seizures
- [ ] Asthma/COPD
- [ ] TIA/Stroke
- [ ] Other:

**Allergies:**

- [ ] NKDA

**Medications:**

- [ ] NONE

**Pertinent Physical Exam Findings:**

**Patient Medications or Medication List Delivered with Report:**

- [ ] Yes
- [ ] No

## VITAL SIGNS

<table>
<thead>
<tr>
<th>Time</th>
<th>Pulse</th>
<th>Blood Pressure</th>
<th>Resp</th>
<th>Glucose</th>
<th>SaO2</th>
<th>Pupils</th>
</tr>
</thead>
<tbody>
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</tbody>
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**Mental Status (AVPU):**

- [ ] Alert
- [ ] Voice
- [ ] Pain
- [ ] Unresponsive

## ECG (if applicable)

**Rhythm:**

12 Lead Interpretation

**ECG Delivered With Report:**

- [ ] Yes
- [ ] No

## EMS Treatment

<table>
<thead>
<tr>
<th>Time</th>
<th>Medication</th>
<th>Dose</th>
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## Notes / Comments

**IV:**

- [ ] Yes
- [ ] No

**IV Fluid Type:**

**Site/Location:**

**Total IV Fluid Volume Given:**

- [ ] mL

**Oxygen:**

- [ ] LPM

## Provider Transferring Care

**Certification Number:**

**Receiving Hospital/Agency Name:**

**Care Transferred To:**

**Time of Transf:**

**EMS Provider Signature:**

**Receiving Healthcare Provider Signature:**

**Signature:**

(Print)