pennsylvania
DEPARTMENT OF HEALTH

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	For Altered Mental Status, Chest pain, or Stroke	
Symptoms/Brief History (sample)	Onset of Persistent Symptoms /Last Seen Normal	
	Date	Time

☐ Diabetes ☐ HTN ☐ Heart Problems ☐ Cancer ☐ Seizures ☐ Asthma/COPD ☐ TIA/Stroke ☐ Other:

Allergies	☐ **NKDA**

Pertinent Physical Exam Findings:

Medications:	☐ **NONE**

Patient Medications or Medication List Delivered with Report ☐ Yes ☐ No

VITAL SIGNS

Time	Pulse	Blood Pressure		Resp	Glucose	SaO2	Pupils	Mental Status (AVPU)			
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive

ECG (if applicable)

Rhythm:	12 Lead Interpretation	**ECG Delivered With Report** ☐ Yes ☐ No

EMS Treatment			Notes / Comments
Time	Medication	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:	
		Receiving Hospital/Agency Name:	Time of Transfr
EMS Provider Signature:		Receiving Healthcare Provider Signature: Signature:__________ (Print) __________	