pennsylvania
DEPARTMENT OF HEALTH

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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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) _____	