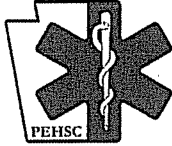

PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL

Your Voice In EMS

RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: 3/21/2012

Subject: EMS Transfer of Care Form

VTR#: 0312-07 Committee/Task Force: EMS Information Task Force

☐Recommended Goal ☒Recommended Policy Change ☐Other:

Recommendation:

The Department of Health should adopt the attached form titled "PENNSYLVANIA EMS TRANSFER OF CARE FORM" as the official Pennsylvania Department of Health EMS transfer of care form to receiving facilities.

Rationale [Background]:

The EMS Information Task Force has been developing Transfer of Care form for over a year. Recently, the Department completed a pilot with a few agencies to test a transfer of care reporting form. The EMS Information Task Force surveyed those sites and found no compelling changes were needed. The pilot form distributed by the Department was altered slightly by the City of Pittsburgh EMS for their pilot. The committee took into consideration the stylistic changes made by the City of Pittsburgh EMS and incorporated some of those changes in the attached form. This form meets the draft regulation requirements set forth in section 1021.41 subsection C for EMS patient care reports.

Medical Review [Concerns]:

Physician representation is present on the EMS Information Task Force and offered their support of this recommendation. No impact on the provision of medical direction is anticipated.

Fiscal Concerns:

The proposed document carries no financial impact to the Department.

Educational Concerns:

The plan for implementation shall include education for EMS providers and hospital personnel. This education at the agency level must include document retention recommendation guidelines and address QI concerns associated with the submission of the PCR and this document. The EMS Information Task Force offers support for the development of any education components.

Plan of Implementation:
Upon acceptance of this recommendation, the Department of Health should:

1. Distribute the attached document to services via Info Bulletin, hospitals, regional councils and the BEMS website.
2. Communicate with hospitals and software vendors that an electronic version capable of being transmitted at point-of-transfer would be supported as an alternative to this form.
3. Offer guidance to agencies who desire to create their own form to ensure that agency specific form elements are consistent with those contained on the Department of Health Transfer of Care Form.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

Board Meeting Comments/Concerns:
Discussion was held at the Board of Directors meeting relative to the application of the data elements and how the form could be modified at the service level. Clarification was offered that the elements on the form are intended to be the minimum required and agencies can create their own forms as long as they include the elements on the Department-approved form. There was also discussion regarding the blank area at the bottom of the provided form, and the committee intended for this blank area to accommodate agency customization, e.g. drug exchange documentation. The discussion at the meeting also centered on the draft regulations that state, "...patient information that is essential for immediate transmission for patient care..." The task force will discuss and identify this at their next meeting.

Signed: JR Henry EGM
President

Date 4/2/12

For PEHSC Use Only – PA Department of Health Response

Accept:____ Table:____ Modify:____ Reject:____

Comments:

Date of Department Response:______________

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/History (SAMPLE)	Onset of Symptoms /Last Seen Normal Date / Time

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

Allergies: ☐ NKDA

Pertinent Physical Exam Findings:

Medications:

Patient's medications or medication list delivered with report ☐Yes ☐No

VITAL SIGNS

Time	Pulse	Blood Pressure		Resp	Pupils	Glucose	SpO2	MENTAL STATUS (AVPU) (Check Best Response)			
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive
								☐ Alert	☐ Voice	☐ Pain	☐ Unresponsive

ECG (if applicable)

Rhythm: 12 Lead Interpretation: ECG delivered with report? Y / N

EMS Treatment

Time	Medication/Treatment	Dose

Notes

IV	Y / N	Size/Location:		Total IV Fluid Volume Given: mL	Oxygen LPM

Provider Transferring Care	Certification Number	Care Transferred To:	
Name (Print)		Receiving Facility/Agency Name	Time of Transfer:
EMS Provider Signature:		Receiving Facility Signature Signature__________ (Print)__________	