pennsylvania
DEPARTMENT OF HEALTH

# EMS Transfer Of Care Form

| | | | | | | |
|---|---|---|---|---|---|---|
| **Patient Name** | | | | | | |
| **Address** | | | | | | |
| **EMS Agency Name / Affiliate Number** | | | **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

| **QRS Provider** | **CERTIFICATION NUMBER** |
|---|---|
| **QRS Provider Signature:** | |
| **EMS Provider** | |
| **EMS Provider Signature:** | |

## CARE TRANSFERRED TO

**Receiving Hospital/Agency Name:**

**Time of Transfer**

**Receiving Healthcare Provider Signature:**

Signature:_____ (Print) _____

# EMS Transfer of Care Form
# Instructions

Many patient safety issues have been associated with times of hand-off of care between healthcare providers. This form is designed to transfer important written information when an EMS agency hands-off care of its patient to another healthcare provider. Although primarily designed to provide critical patient information to a hospital emergency department, the form can be used when one EMS agency/service transfers care to another EMS agency/service.

This form provides the receiving facility with a brief summary of key patient information that is required to reduce the possibility of medical error from miscommunication of information. Although the information on the form is not a complete EMS PCR, it should be assumed that this form may become a permanent part of the patient's medical record at the receiving facility/ hospital.

A copy of the form provides helpful notations that will assist the EMS provider when the EMS PCR is completed later. If the form is not provided in a duplicate or electronic format, the EMS provider should make a photocopy of the form at the receiving facility. In addition to assisting with the writing of the PCR, the provider's EMS agency may have a policy that requires retention of the form as part of the agency's documentation.

**The form should be secured in the same manner as other patient records that contain protected healthcare information.**

**Completion of the Form:**

**Patient Identification:** Patient name, date of birth, age, and date of EMS incident are important to identify patient and link this form to hospital records. If EMS provide has not positively identified the patient, write "unknown" in the name/date spaces.

**Chief Complaint and Symptoms/ Brief History:** Chief complaint should be the patient's primary complaint. Provide a brief summary of pertinent symptoms or history of incident. For example, the pertinent history for an MVC would include brief mechanism, patient restraint, airbag deployment, etc. Other examples of pertinent symptoms would include location, quality, and intensity of pain or history of witnessed loss of consciousness, etc.

**Time/Date of Symptom Onset:** Although this box could be used to document time/date of symptom onset in general, it is particularly critical for suspected STEMI, suspected stroke, or head trauma. EMS provider must document the time of onset of steady or maximal persistent chest pain in STEMI, the time last seen normal for suspected stroke, and the time of injury for trauma.

**Allergies:** List in provided spaces. Continue on back if list exceeds space provided.

**Pertinent Physical Exam Findings:** This section should be used to document pertinent physical exam findings in patients with medical conditions. For patients with traumatic injuries, list all injuries that are identified.

**Medications:** It is not necessary to list a patient's medications if the EMS crew delivers either all of the medications in their containers or a current list of the patient's medications (e.g. list from skilled nursing facility or patient's up-to-date wallet or home list) at the time of hand-off. Otherwise, list all medications known to the EMS provider. Remember that inhalants, over-the-counter medications, herbal medications/ vitamins, are frequently missed. Continue on back if list exceeds space provided.

**Vital Signs:** List at least one complete set of vital signs (pulse, respirations, BP) and check appropriate mental status for all patients. List blood glucose level and pulse oximetry reading, when obtained. It is not necessary to list every set of vital signs obtained, but if initial and final VS vary significantly, both should be listed. If the transfer form is used to document care transferred from one EMS provider to another, list at least one set of vital signs from each provider.

**EMS ECG/ 12-Lead ECG:** Copies of **every** 12-lead ECG (and any single lead ECG that documents a dysrhythmia) must be left with the receiving facility at time of hand off. These must be labeled with patient name, DOB, and time/date of ECG.

**EMS Treatments/ Medications:** List ALL medications administered by EMS provider with time and dose. Continue on back if list exceeds space provided.

**IV Fluids/ Oxygen:** List any IV fluid administered by name and total volume administered at time of hand-off to receiving facility/ hospital. List oxygen provided at time of hand-off.

**Transfer of Care:** This section is used to document the transfer of care from the final EMS provider to the healthcare professional at the receiving facility/ hospital. This line documents the printed name and certification number of the transferring EMS provider, the name of the receiving facility, and the time/date of hand-off to the receiving facility. The bottom of the form is signed by both the transferring EMS provider and the healthcare professional that accepts the report at the receiving facility.

**Feedback:**

This purpose of this pilot is to evaluate the EMS hand-off form that accompanies these instructions. As a pilot form, the Bureau of EMS is interested in feedback from EMS providers and healthcare facilities that use the form. Please provide specific feedback as a summary from your EMS agency. All comments should be sent to the Commonwealth EMS Medical Director at the Bureau of EMS, Pennsylvania Department of Health.

Thank you for your willingness to pilot this important patient safety initiative.