South Central PA Patient Care Transfer Form

EHS Federation

Demographics:

Date of Service:_____ Dispatched @:_____

EMS Agency: _____Unit:_____

Crew Chief: _____ Crew:_____

Transported: ○ ALS ○ BLS Chief Complaint:_____

Provider Impression: _____

Incident Location:

○ Home ○ ECF ○ Work ○ Roadway ○Other

Patient Info:

Patient's Name: _____

SS #: _____DOB:_____ Age: ____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Sex: Male ○ Female ○

STEMI / CVA:

Onset Time:

_____

Date:

_____

O: _____

P: _____ _____

Q: _____

R: _____

S: _____**T:**_____

Treatment:

○ 12 Lead ○ IV/IO _____

○ BG ___ ○ ETT _____

○ Meds

Initial GCS

Eyes	*Verbal*	*Motor Resp*
○ 4 Spont.	○5 Oriented	○ 6 Obeys
○ 3 Voice	○ 4 Confused	○ 5 Loc Pain
○ 2 Pain	○ 3 Inapprop.	○ 4 Withdraw
○ 1 None	○ 2 Garbled	○ 3 Flexion Pain
	○ 1 None	○ 2 Extension Pain
		○ 1 None

Total: Time:

Additional Complaints

○ Chest pain
○Shortness of breath
○Asthma
○Dizziness
○Headache
○Nausea
○Vomiting
○Diarrhea
○Syncope
○Weakness
○Chills
○Bleeding
○Cough
○ Fever
○OB/Gyn
○Other

Lung Sounds

○ Clear
○ Rhonchi
○ Rales
○ Wheezes
○Diminished
○ Absent

Skin Temp

○ Normal
○ Cool
○ Hot
○ Warm

Skin Color

○ Normal
○ Pale
○ Cyanotic
○ Flushed
○ Jaundice
○ Mottled
○ Ashen

Skin

○ Moist
○ Dry
○ Wet

Oxygen: ○ N/C ○ NRB ○BVM ○Nebulizer ○CPAP L/M:_____

○ **Additional Information Attached**

Additional Information (SAMPLE):

Vitals: **Time** **Pulse** **BP** **Resp.** **SPO2** **EKG** **End Tidal CO2 Mental Status**

Receiving Facility:_____ **Time Care Transferred:**_____

Representative Name: _____ **Signature:**_____

RN/PA/MD/DO