pennsylvania
DEPARTMENT OF HEALTH

EMS Transfer of Care Form

Patient Name: Harry Block						Phone #: 267 252 8950	
Patient Next of Kin Name / Phone: /		Address: 920 Union St					
EMS Agency Name / Affiliate Number: Goshen Fire Company / 15006		City: Reading				State: PA	Zip: 19604
Date: 11/11/25	Time:	Incident Number:	Age: 73	Gender (M / F): M	Date of Birth: 9-25-52	SSN:	
Incident Location: Panera Bread		Chief Complaint / Provider Impression: Anxiety					

BRIEF HISTORY / PERTINENT SYMPTOMS

Cardiac Stents
Anxiety
Back surgery.

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

Before Arrival pt had 4mg of Xanax.

MEDICATIONS ☐ NONE

Clonazepam
Nitroglycerin

Stent Cardiac
Anxiety
~~CHF~~

Patient Medications or Medication List Delivered with Report ☐ Yes

ALLERGIES ☒ NKDA

VITAL SIGNS

Time	Pulse	Blood Pressure	Resp	Glucose	SaO2	Mental Status (AVPU)
1455	73	146 81	14		96	☒ Alert ☐ Verbal ☐ Pain ☐ Unresponsive
						☐ Alert ☐ Verbal ☐ Pain ☐ Unresponsive
						☐ Alert ☐ Verbal ☐ 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	CERTIFICATION NUMBER	CARE TRANSFERRED TO
QRS Provider		Receiving Hospital/Agency Name: Time of Transfer
QRS Provider Signature:		
EMS Provider		Receiving Healthcare Provider Signature:
EMS Provider Signature: Eva Ashberg		Signature (Print)

EMS Patient Non-Treatment and/or Non-Transport Checklist

EMS Agency: Gosher Date: 11/11/25 Time: _____

Patient Name: HARRY Bloch Age: 73 Phone #: 267 252 8956

Incident Location: Panera Bread Incident # _____

Situation of Injury/Illness: _____

Check marks in shaded areas require consult with Medical Command before patient release

Patient Assessment:

Suspected serious injury or illness based upon patient - History, mechanism of injury, or physical examination: __ Yes __ No

18 years of age or older: X Yes __ No
~~Without ability to speak with guardian~~

Patient Oriented to:
Person __ Yes __ No
Place __ Yes __ No
Time __ Yes __ No
Event __ Yes __ No

Any evidence of:
Suicide attempt/ideation? __ Yes __ No
Head Injury? __ Yes __ No
Intoxication? __ Yes __ No
Chest Pain? __ Yes __ No
Dyspnea? __ Yes __ No
Syncope? __ Yes __ No
If head trauma & taking aspirin/anticoagulant? __ Yes __ No
12-lead done? __ Yes __ No

Vital Signs:		*Consult Medical Command if:*
Pulse	73	<50bpm or >100 bpm
Sys BP	146	<100 mm Hg or > 200 mm Hg
Dia BP	81	<50 mm Hg or > 100 mm Hg
Resp	14	< 12rpm or > 24rpm

If altered mental status or diabetic (optional for BLS)
Chemstrip/Glucometer: _____mg/dl < 60 mg/dl

If chest pain, S.O.B. or altered mental status –
SpO2 (if available): 96% < 95%

Risks explained to patient: up to and including death ✓
Patient understands clinical situation __Yes __No
Patient verbalizes understanding of risks __Yes __No
Patient's plan to seek further medical evaluation: _____

Medical Command:

Physician contacted: _____ Facility: _____ Time: _____

Command spoke to patient: Yes __ No X Command not contacted X Why? _____

Medical Command orders: _____

Patient Outcome:

___ Patient refuses treatment/ transport to a hospital against EMS advice
___ Patient accepts transportation to hospital by EMS but refuses any or all treatment offered (specify treatments refused: _____)
___ Patient does not desire transport to hospital by ambulance, EMS believe alternative treatment/transportation plan is reasonable

This form is being provided to me because I have refused assessment, treatment and/or transport by an EMS provider for myself or on behalf of this patient. I understand that EMS providers are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I may change my mind and call 911 if treatment or assistance is needed later. I also understand that treatment is available at an emergency department 24 hours a day. I acknowledge that this advice has been explained to me by the EMS crew and that I have read this form completely and understand its terms.

X _____ 11/11/25 _____

Signature (Patient or Other) Date EMS Provider Signature

_____ X _____

If other than patient, print name and relationship to patient Witness Signature