



EMS Transfer of Care Form

Patient Next of Kin Name / Phone		Patient Name		Phone #	
		Harry Block		267 252 8952	
EMS Agency Name / Affiliate Number		Address			
Goshen Fire Company / 15006		920 Union St			
Date	Time	Incident Number	City	State	Zip
11/11/08			Reading	PA	19604
Age	Gender (M/F)	Date of Birth	SSN		
73	M	9-25-52			

Incident Location:

Chief Complaint / Provider Impression:

Anxiety

BRIEF HISTORY / PERTINENT SYMPTOMS

Cardiac events
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 4 mg
of Xanax.

MEDICATIONS

NONE

Clonazepam
Nitroglycerin

Stent cardiac
Anxiety
GHB

ALLERGIES

NKDA

Patient Medications or Medication List Delivered with Report Yes

VITAL SIGNS

Time	Pulse	Blood Pressure	Resp	Glucose	SaO2	Mental Status (AVPU)			
1455	73	146 81	14		96	<input checked="" type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
						<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive
						<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain	<input type="checkbox"/> Unresponsive

ECG

Rhythm:

12-lead ECG Interpretation:

Copy of Rhythm Strip/ all 12-lead ECGs

Delivered with Report Yes

NOTES / COMMENTS

Time	Medication/ Intervention	Dose			

IV <input type="checkbox"/> Yes	IV Fluid Type:	Size/Location:	Total IV Fluid Volume Given:	Oxygen:
<input type="checkbox"/> No			mL	LPM

PROVIDER TRANSFERRING CARE	CERTIFICATION NUMBER	CARE TRANSFERRED TO
QRS Provider		Receiving Hospital/Agency Name: _____ Time of Transfer _____

QRS Provider Signature:	Receiving Healthcare Provider Signature:
EMS Provider Signature <i>Hra Ashbee</i>	Signature _____ (Print) _____

EMS Provider Signature	Signature _____ (Print) _____
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EMS Provider Signature	Signature _____ (Print) _____
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EMS Patient Non-Treatment and/or Non-Transport

Checklist

EMS Agency: GoshenDate: 11/11/25 Time: _____Patient Name: HARRY BLOCH Age: 73 Phone #: 2167 252 8956Incident 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 No18 years of age or older: Yes NoAny evidence of: Suicide attempt/ideation? Yes No

Without ability to speak with guardian

Head Injury? Yes NoPatient Oriented to: Person Yes NoIntoxication? Yes NoPlace Yes NoChest Pain? Yes NoTime Yes NoDyspnea? Yes NoEvent Yes NoSyncope? Yes NoIf head trauma & taking aspirin/anticoagulant? Yes No12-lead done? Yes No

Vital Signs:	Consult Medical Command if:	If altered mental status or diabetic (optional for BLS)
Pulse <u>73</u>	<50bpm or >100 bpm	Chemstrip/Glucometer: _____ mg/dl < 60 mg/dl
Sys BP <u>140</u>	<100 mm Hg or > 200 mm Hg	
Dia BP <u>81</u>	<50 mm Hg or > 100 mm Hg	
Resp <u>14</u>	< 12rpm or > 24rpm	If chest pain, S.O.B. or altered mental status -- SpO2 (if available): <u>96%</u> < 95%

Risks explained to patient: up to and including death Patient understands clinical situation Yes NoPatient verbalizes understanding of risks Yes No

Patient's plan to seek further medical evaluation: _____

Medical Command:

Physician contacted: _____ Facility: _____ Time: _____

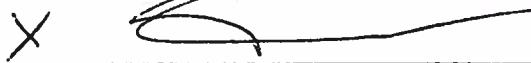
Command spoke to patient: Yes No Command not contacted Why? _____

Medical Command orders: _____

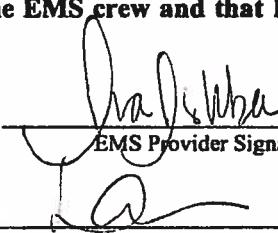
Patient Outcome:

- 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.



Signature (Patient or Other)

Date 11/11/25EMS Provider Signature Witness Signature 

If other than patient, print name and relationship to patient