pennsylvania
DEPARTMENT OF HEALTH

EMS Information Bulletin 2021-03

DATE: April 8, 2021

SUBJECT: Updated Transfer of Care Form

TO: PA EMS Providers
PA EMS Agencies
PA EMS Agency Medical Directors
PA Regional EMS Councils

FROM: Dylan Ferguson, Director
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PA Department of Health
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Since 2014 the Pennsylvania EMS regulations (28 Pa. Code § 1021.41) has included a requirement for providing patient information to the receiving Health Care Provider at the time the patient is transferred.

The Bureau of EMS provides a template transfer of care form, which contains all the elements that are required pursuant to 28 Pa. Code § 1021.41 (c).

At the request of some receiving facilities advocating on behalf of patients. The transfer of care form has been updated to include an added field to document the name and phone number for the patient's next of kin or emergency contact.

This information can be critical in assisting our receiving facilities as they manage a patient's condition, particularly in situations that involve time sensitive emergencies such as stroke and trauma care.

EMS agencies and regions that already have printed copies of the form may continue to use those forms until such time that supplies are exhausted. At that time all agencies and regional councils must transition to the updated form. If an agency is using an electronic format, they must implement this immediately.

The updated form is attached and is available for download from the Bureau of EMS webpage.

Please direct any questions to your regional EMS council.

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EMS Transfer of Care Form

Patient Name						
Patient Next of Kin Name / Phone /	**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	**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:		Signature:_____ (Print) _____	