MIDSTATE EMS Transfer of Care Form	Date:	Time: Transfer time:	EMS Agency: EMS Provider Name: Certification Number: Receiving hospital:

Patient name:	Phone:	Date of birth:	Age:	Female Male

Chief complaint:	Provider impression:
History/Exam	For Altered Mental Status, chest pain or stroke
Symptoms/Brief history (SAMPLE)	Onset of persistent symptoms/last known normal Date: Time:

History of: (CIRCLE): DIABETES HTN CARDIAC CANCER SEIZURES ASTHMA/COPD TIA/STROKE
OTHER:

Allergies	NKDA	Medications	
		Were meds or med list delivered with patient?	

Pertinent physical exam findings:

Vital signs								***ECG***
Time	pulse	resp	Blood pressure	glucose	spO2	Pupils	AVPU	Rhythm:
								12 lead interpretation:
								Ecg delivered?

EMS Treatments		Notes/comments
time	Procedure/medication	

IV started/attempted?(details):

Ems provider signature:	Receiving healthcare provider signature:

The complete Chart is expected at the receiving hospital within 4 hours of delivery of the patient

Midstate 10-10