BUREAU OF EMS AND TRAUMA
INTERFACILITY TRANSPORT FORM
PART A - DRUG REPORT

Electronic EMS Patient Care Record #: ______________________________

Patient Name: ______________________________ DOB: ______________
LAST FIRST MI MM/DD/YYYY

Referring Physician: ____________________ Transferring Facility: ____________________

Accepting Physician: ____________________ Receiving Facility: ____________________

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Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete.

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DIAGNOSIS: **(1)**____________________

(2)____________________

(3)____________________

LAST VITAL SIGNS: Time: ________ Initials: ______

HR: ________ B/P: ______/______ RR: ________

SpO2:________ BGL: ________ Other: ________

IV Fluids: ____________________ Rate: ____________________

Medications: ____________________

Dosage / Rate/Concentration:____________________

Comments/Additional Orders: ____________________

IV Fluids:____________________ Rate: ____________________

Medications:____________________

Dosage / Rate/Concentration:____________________

Comments/Additional Orders: ____________________

IV Fluids:____________________ Rate: ____________________

Medications:____________________

Dosage / Rate/Concentration: ____________________

Comments/Additional Orders: ____________________

PLEASE CHECK THE INTERFACILITY DEVICES BEING USED IN THIS TRANSPORT ON DEVICE REPORT, PART B AND VENTILATOR SETTINGS, PART C.

This report was given by (**Print name**):____________________RN / PA / NP / MD / DO

Signature: ____________________ Date: ______________ Time: ______________

(None of the drugs being sent with this patient are part of an experimental program.)

This report was accepted by (**EMT-P signature**):____________________ Date:______________

<u>EMS Service must retain a copy of this form for their records.</u>

If any problems are experienced en route, the EMT-P must contact on-line medical control.

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency

PART B - DEVICE REPORT

Electronic EMS Patient Care Record #: ____________________

Patient Name: ____ DOB: ________________________

LAST FIRST M MM/DD/YYYY

Referring Physician: __________________________ Transferring Facility: _______________________________

Accepting Physician: __________________________ Receiving Facility: _______________________________

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Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete

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INTERFACILITY INVASIVE/IMPLANTED DEVICES USED IN THIS TRANSPORT

Check all devices being used: [ ] Not Applicable

___ Automatic Internal Cardiac Defibrillator (AICD)

___ Arterial Lines, Arterial Sheathes

___ Tube Thoracostomy/Chest Tube

___ Percutaneously Placed Central Venous Catheters (does not include Swan-Ganz catheters)

___ Peritoneal Dialysis Catheters

___ Epidural Catheters

___ Urethral/Suprapubic Catheter

___ Implantable Central Venous Catheters

___ Nasogastric/Orogastric Tubes

___ Surgically Placed Gastrointestinal Tubes

___ Percutaneous Drainage Tubes

___ Completely Implantable Venous Access Port

___ Surgical Drains

Comments/Additional Orders:

This report was given by (print name): ____ RN / PA / NP / MD/ DO

Signature: ____ Date : ________________ Time: ______________

This report was accepted by (EMT-Paramedic) Signature: ______________________________ Date: ___________ Time: ___________

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency

PART C – VENTILATOR SETTINGS

Electronic EMS Patient Care Record #:____________________

Patient Name: ____DOB:____________________
LAST FIRST MI MM/DD/YYYY

Referring Physician: _____________________________Transferring Facility:___________________________

Accepting Physician:_____________________________ Receiving Facility:____________________________

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Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete.

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If a ventilator is used during interfacility transport the following information MUST be reported to the receiving Paramedic and attested to by the RT / NP / PA / MD / DO turning over the patient.:

Facility Settings: to be filled out by RT/NP/PA/MD/DO

Mode (check one): ☐AC ☐SIMV ☐PSV

☐PRVC ☐BiPAP ☐Other:____________

Patient Sedated: ☐No ☐Induction ☐Maintenance

Patient Paralyzed: ☐No ☐Induction ☐Maintenance

ET Tube Size: _____ Depth: _____ @ Teeth/Lip

Respiratory Set Rate: _______ Actual Rate: _______

Tidal Volume (VT): _________

Fraction of Inspired Oxygen (FiO2): _________

Insp. Press/PS: __________ PEEP: _________

I:E ratio:____________ PIP: ______________

SpO2: ______________ ETCO2: ________________

Additional Orders/ Comments:

Initial Transport Settings: to be filled out by EMS Provider

Mode (check one): ☐AC ☐SIMV ☐PSV

☐PRVC ☐BiPAP ☐Other:____________

Patient Sedated: ☐No ☐Induction ☐Maintenance

Patient Paralyzed: ☐No ☐Induction ☐Maintenance

ET Tube Size: _____ Depth: _____ @ Teeth/Lip

Respiratory Set Rate: _______ Actual Rate: _______

Tidal Volume (VT): _________

Fraction of Inspired Oxygen (FiO2): _________

Insp. Press/PS: __________ PEEP: _________

I:E ratio:____________ PIP: ______________

SpO2: ______________ ETCO2: ________________

Our equipment is able to meet the above settings and I attest to my competency to operate this equipment during transport

____
Paramedic Signature Date Time

This report was given by (print name): ____ RN / PA / NP / MD/ DO

Signature: ____ Date : ________________ Time: ______________

This report was accepted by (EMT-Paramedic) Signature: ______________________________ Date: ___________ Time: __________

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency