Great Falls Emergency Services

Time Call Received _____
Callers Name _____
Return Number _____
Person Receiving call _____

AMBULANCE TRANSFER INFORMATION FORM

Pt's Origination Point		Pick Up Time
Pt's Destination Point		Pick Up Date

Pts Name: _____
Last Name First Name

DOB: _____/_____/_____ **Age:_____** **Sex:** M F **SS #:** _____

PT's Chief Complaint: _____
Sending Phyician_____
Reason For Transfer / Diagnosis: _____

Are services available at the destination facility that are not available at the sending facility?
Yes No If yes, what are they?_____

Contact Precautions: Yes No If yes, what are they?_____

Pertinent Medical Hx: _____

Medications **(or attached List):** _____
Allergies: _____

Metal Status: Alert __/4 Verbal Painful Unresponsive **GCS:** _____
Current Vital Signs: Time_____ BP_____ HR_____ Resp _____ SpO2 _____
ECG Rhythm_____
Oxygen Yes_____ No_____ L/min _____
Intubated Yes_____ No_____ Ventilator Yes_____ No_____
IV Access Yes_____ No_____ Fluid _____ Rate _____
Pump Infused Medication_____
Medication Flow Rate_____/HR
Blood Products Yes_____ No_____ Blood type_____ Volume Rate_____
Other Pertinent Information: _____
Special positioning required Yes_____ No_____
Copy of current medical records/physician orders Yes_____ No_____
Receiving Physician _____
Required Transfer Forms: ***Physicians Certified Statement (PCS)***
Hospital Face Sheet
Paperwork for Receiving Facility