

**SIERRA – SACRAMENTO VALLEY EMS
TRANSFER OF CARE / INTERIM PT. CARE REPORT**



DATE _____

CALL LOCATION		EMS UNIT#		INCIDENT#						
NAME		SEX	AGE	D.O.B. / /						
ADDRESS		CITY		PHONE# ()						
CHIEF COMPLAINT				WEIGHT						
P.Q.R.S.T. / TIME OF SYMPTOM ONSET (TIME OF INCIDENT & MECHANISM OF INJURY FOR TRAUMA PT's)										
PERTINENT HISTORY		MEDICATIONS			MEDICATION ALLERGIES					
TIME	GCS			BP	PULSE	RESP.	PAIN	RHYTHM	SpO2	BY
	E	V	M							
							/ 10			
							/ 10			
							/ 10			
							/ 10			
PERTINENT PHYSICAL FINDINGS										
TIME	TREATMENT, MEDICATION, DOSE, ROUTE AND RESPONSE (INCLUDE TOTAL IV VOLUME)									BY

Name, ID, & contact number of the prehospital provider completing this form _____