



**DHEC – DIVISION OF EMS AND TRAUMA
INTERFACILITY TRANSPORT FORM
PART A - DRUG REPORT**

EMS Patient Care Form #: _____

Patient Name: _____ DOB: _____
LAST FIRST MI MM/DD/YYYY

Referring Physician: _____ Transferring Facility: _____

Accepting Physician: _____ Receiving Facility: _____

Instructions: Part A (Drug Report) and Part B (Device Report) must be completed by and signed by the sending facility. Attached Part A (Drug Report) and Part B (Device Report) to EMS ePCR once transport is complete.

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
THE BACK PAGE OF THIS FORM.**

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: _____

EMS Service must retain a copy of this form for their records.

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

White form: EMS Copy Yellow Form: Accepting Facility Copy Pink Form: Sending Facility Copy

PART B - DEVICE REPORT

EMS Patient Care Form #: _____

Patient Name: _____ DOB: _____
LAST FIRST M MM/DD/YYYY

Referring Physician: _____ Transferring Facility: _____

Accepting Physician: _____ Receiving Facility: _____

Instructions: Part A (Drug Report) and Part B (Device Report) must be completed by and signed by the sending facility. Attached Part A (Drug Report) and Part B (Device Report) to EMS ePCR once transport is complete.

INTERFACILITY INVASIVE/IMPLANTED DEVICES USED IN THIS TRANSPORT

Check all devices being used:

- 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: _____

White form: EMS Copy Yellow Form: Accepting Facility Copy Pink Form: Sending Facility Copy