Transporting Agency:	Date/Time Pt Contact:	Date/Time Pt Care Transferred:

Patient Information

Patient Name:	DOB:
Race:	Gender:
Patient Address:	
Guardian/Emergency Contact Name, Address and Phone:	

Past Medical History

Med/Surg History:	Meds:	Allergies: NKDA ☐ Yes ☐
Medical hx rec'd from:	Pregnancy:	Advanced Directive:

Patient Complaint

Chief Complaint:	Secondary Complaint:

Date/Time Symptom Onset:	Signs of alcohol/drug use: No ☐ Yes ☐	Suspected drugs taken:	Date/Time Last Known Well:

Assessments

Time	Mental Status	Neurological	Head	Face	Eye	Neck	Heart	Chest Lungs	Abdomen	Pelvis Genitals	Spine	Extremity	Skin

Vitals

Time	Crew	BP	Pulse	Resp. Rate	Glucose	Sp02	CO2 / CO	Pain Scale	AVPU	Temp	Stroke	GCS	Other

Procedures and Treatments

Time	Name	Location	Size of Equip	Success	Response	Comments:

Medications Administered

Time	Medication	Route	Dosage	Response	Comments:

At-Risk Person: No ☐ Yes ☐	Drug Use Screening: No ☐ Yes ☐	Naloxone Kit offered: No ☐ Yes ☐	Naloxone Kit Left: No ☐ Yes ☐	Number of Kits left:

Narrative or Notes