WMRMCC
West Michigan Regional Medical Control Consortium

Approved: TRIAL
Revised: 10/6/22

Ambulance Interfacility Transfer Form

Patient Information

Weight _____ Height _____

Allergies _____

Pertinent PMH: _____

Patient Sticker

Resources Required to be sent with EMS:

☐ Face Sheet ☐ PCS ☐ EMTALA Form ☐ Original Petition & Certification

☐ Advanced Directives/Mi-POST ☐ Patient Home Medication List ☐ Medication Administration Record (MAR)

Last set of Vital Signs prior to transfer of care:

Time: _____ BP: _____ / _____ HR: _____ Resp: _____ Temp: _____ SaO2: _____

Medication Order(s): Infusion rates, doses and titration instructions for medications to be continued or administered during the EMS Interfacility transfer.

Medication Name	Infusion Rate/Dose	Instructions During Transport

Were Drug Reference Guides provided to EMS personnel for medications that will be administered during interfacility transfer which are outside of prehospital protocol, when requested by EMS Providers? ☐ Yes ☐ No

Respiratory/Ventilator: ☐ Adult ☐ Pediatric ☐ Infant *check one*

MODE	BREATH RATE	TIDAL VOLUME	PRESS CONTROL	INSP TIME	PRESS SUPP	FiO_2%	SENS

PEEP	ET SIZE#	ET DEPTH @ LIP		HIGH PRESS	LOW PRESS	LOW MIN VOL
			ALARMS:			

Other orders: _____

_____

Spinal Precautions required: ☐ Head of Bed elevated ☐ Logroll only/spinal precautions ☐ Maintain c-collar

Sending Facility: _____ Contact Phone#_____

Receiving Facility & Unit: _____ Contact Phone#_____

RN Information: The information above was reviewed.

Date _____ Time _____ RN signature _____

Physician/APP/Provider Information: The above orders were reviewed and approved.

Date _____ Time _____ Physician signature _____

CONTACT SENDING MEDICAL CONTROL FACILITY WITH QUESTIONS