Attachment B

SCDHEC - EMS DIVISION
INTERFACILITY TRANSPORT FORM
PART A - DRUG REPORT

Patient Care Form #: _____

Patient Name: _____ DOB: _____ SS #: _____
LAST FIRST

Referring Physician: _____ Transferring Facility: _____

Accepting Physician: _____ Receiving Facility: _____

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Instructions: Part A (Drug Report) and Part B (Device Report) must be completed by and signed by the sending physician **or** nurse.

****

DIAGNOSIS: (1)_____ **LAST VITAL SIGNS:**_____

(2)_____

(3)_____

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 (**physician/nurse signature**): _____ Date: _____

(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.

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