



# Central New York Emergency Medical Services Interfacility Transfer Document



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Diagnosis: \_\_\_\_\_ Condition: stable \_\_\_\_\_ unstable \_\_\_\_\_

Agency: \_\_\_\_\_ Hospital Origin: \_\_\_\_\_ Hospital Destination: \_\_\_\_\_

**PHYSICIANS: This area must be completed for all transfer medications, PRIOR to transport by EMS. Thank you.**

Check all that apply.

\_\_\_\_\_ **Intravenous Fluids:** Fluid: \_\_\_\_\_ Infusion Rate: \_\_\_\_\_

\_\_\_\_\_ **Medication – Continuous Infusion**

Medication ordered: \_\_\_\_\_

Infusion Rate: \_\_\_\_\_

Parameters:

Vital signs:

Maintain BP above \_\_\_\_\_ and below \_\_\_\_\_

Pain: as tolerated

Other: \_\_\_\_\_

\_\_\_\_\_ **Medication – PRN**

Medication ordered: \_\_\_\_\_

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Route: IV push: \_\_\_\_\_ IM \_\_\_\_\_ SQ \_\_\_\_\_ Other \_\_\_\_\_

Parameters:

Vital signs:

Maintain BP above \_\_\_\_\_ and below \_\_\_\_\_

Pain: as tolerated

Other: \_\_\_\_\_

Ordering Physician: Name \_\_\_\_\_

Print

Signature

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

**EMS Use ONLY**

Provider: \_\_\_\_\_

Printed Name

Signature

AEMT #

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

PCR #: \_\_\_\_\_

**CNYEMS Use ONLY**

Date Received: \_\_\_\_\_ Date Reviewed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

QA Done by: \_\_\_\_\_