SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Preliminary Handoff Form

Date	Provider & Ambulance #	Incident #	Sex ☐ M ☐ F	Age	DOB	Incident Location
Name (Last, First)				Area Code	Phone #	
Permanent Mailing Address					Apt #	
City				State	Zip Code	Chief Complaint

Dispatch Time: _____ At Patient Time: _____
Depart Scene: _____ ED Arrival Time: _____
☐ STEMI – Symptom Onset Time: ____:____hrs
☐ Stroke – Last Time w/o Symptoms:

Advancement Procedure(s)	Size / Qty
☐ Venous Access ☐ IV ☐ IO	
☐ Venous Access ☐ IV ☐ IO	
☐ Cardiac Monitor ☐ 12-Lead ECG	
ECG Documentation: ☐ Attached ☐ Transmitted	
☐ Vagal Maneuver ☐ TCP: Rate ____/____mA	
☐ Defibrillation ☐ Cardioversion	
☐ _____J ☐ _____J ☐ _____J ☐ _____J	
☐ Advanced Airway: ☐ BIAD ☐ ETT	Size / Depth

Medication	Dose / Route	Time
☐ Oxygen		

Basic Procedure(s)

☐ Airway NPA	☐ Airway OPA	
☐ Suctioning	☐ CPR	☐ BVM
☐ CPAP	☐ Splint Extremity	
☐ Wound Care		
☐ Hemorrhage Control TQ Time: _____	☐ Spinal Motion Restriction	
☐ Other: _____	☐ Other: _____	

Time	B/P	Pulse	Resp	ECG	BGL	LOC	SpO2	ETCO2	GCS	RACE	RTS

MOI: ☐ MVC ☐ Pedestrian ☐ Fall ☐ Assault ☐ CSW ☐ Stabbing ☐ Heat ☐ Cold ☐ Bite/Sting
☐ Thermal ☐ Other: _____ **Safety Equipment:** ☐ Helmet ☐ Seatbelt ☐ SRS

Narrative:

Pt Allergies ☐ NKDA ☐ Unknown

Pt Medication ☐ None ☐ Unknown

Pt History ☐ None ☐ Unknown
☐ Cardiac ☐ Hypertension
☐ Diabetic ☐ GI / GU
☐ Respiratory ☐ COPD ☐ Asthma
☐ Behavioral ☐ Substance Abuse
☐ Neurological ☐ Stroke ☐ Seizure
☐ Other: _____
☐ Other: _____
☐ Other: _____

Attendants	Print Name	EMT Number	Print Name	EMT Number
		SC		SC

Receiving Facility Signature	Name	Signature

This is a preliminary patient transfer form – this is not a final patient care report.

4484-ENG-DPH (05/2025)

Glascow Coma Score					
Best Eye Response (4)		**Best Verbal Response (5)**		**Best Motor Response (6)**	
1	No eye opening	1	No verbal response	1	No motor response
2	Eye opening to pain	2	Incomprehensible sounds	2	Extension to pain
3	Eye opening to verbal command	3	Inappropriate words	3	Flexion to pain
4	Eye opening spontaneously	4	Confused	4	Withdrawal to pain
		5	Oriented	5	Localizes pain
				6	Obeys commands

Revised Trauma Score			
Glascow Coma Scale (GSC)	**Systolic Blood Pressure (SBP)**	**Respiratory Rate (RR)**	**Coded Value**
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1
3	0	0	0

This is a preliminary patient transfer form – this is not a final patient care report.

Preliminary Handoff Form

Instructions for Completing 4484-ENG-DPH

PURPOSE: Within sixty (60) minutes of the completion of the call, the EMS Agency will make each ePCR available to the receiving facility. The EMS Agency may substitute this paper information sheet, provided the ePCR is made available to the receiving facility no later than twenty-four (24) hours from completion of the call.

AUDIENCE: Ambulance crews transporting patients to hospitals.

INSTRUCTIONS: This form will be filled out by the primary caregiver and turned over to the receiving facilities staff upon transfer of patient care.

OFFICE MECHANICS & FILING: This form is left with the hospital staff; no copy is retained for DPH or EMS.