SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

BUREAU OF EMS AND TRAUMA
INTERFACILITY TRANSPORT FORM
PART A - DRUG REPORT

Electronic EMS Patient Care Record #: _____

Patient Name: _____ DOB: _____
LAST FIRST MI MM/DD/YYYY

Referring Physician: _____ Transferring Facility: _____

Accepting Physician: _____ Receiving Facility: _____

****

Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete.

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DIAGNOSIS: **(1)**_____

(2)_____

(3)_____

LAST VITAL SIGNS: Time: _____ Initials: _____

HR: _____ B/P: _____/_____ RR: _____

SpO2:_____ BGL: _____ Other: _____

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 DEVICE REPORT, PART B AND VENTILATOR SETTINGS, PART C.

This report was given by (**Print name**):_____RN / PA / NP / MD / DO

Signature: _____ Date: _____ Time: _____

(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.

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency

PART B - DEVICE REPORT

Electronic EMS Patient Care Record #: _____

Patient Name: _____ DOB: _____
LAST FIRST M MM/DD/YYYY

Referring Physician: _____ Transferring Facility: _____

Accepting Physician: _____ Receiving Facility: _____

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Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete

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INTERFACILITY INVASIVE/IMPLANTED DEVICES USED IN THIS TRANSPORT

Check all devices being used: ☐ **Not Applicable**

- ☐ Automatic Internal Cardiac Defibrillator (AICD)
- ☐ Arterial Lines, Arterial Sheathes
- ☐ Tube Thoracostomy/Chest Tube
- ☐ Percutaneously Placed Central Venous Catheters (does not include Swan-Ganz catheters)
- ☐ Peritoneal Dialysis Catheters
- ☐ Epidural Catheters
- ☐ Urethral/Suprapubic Catheter
- ☐ Implantable Central Venous Catheters
- ☐ Nasogastric/Orogastric Tubes
- ☐ Surgically Placed Gastrointestinal Tubes
- ☐ Percutaneous Drainage Tubes
- ☐ Completely Implantable Venous Access Port
- ☐ Surgical Drains

Comments/Additional Orders:

This report was given by (print name): _____ RN / PA / NP / MD / DO

Signature: _____ Date : _____ Time: _____

This report was accepted by (EMT-Paramedic) Signature: _____ Date: _____ Time: _____

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency

PART C – VENTILATOR SETTINGS

Electronic EMS Patient Care Record #:_____

Patient Name: _____DOB:_____
LAST FIRST MI MM/DD/YYYY

Referring Physician: _____Transferring Facility:_____

Accepting Physician:_____ Receiving Facility:_____

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Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility, and attached to the EMS ePCR once transport is complete.

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If a ventilator is used during interfacility transport the following information MUST be reported to the receiving Paramedic and attested to by the RT / NP / PA / MD / DO turning over the patient.:

Facility Settings: to be filled out by RT/NP/PA/MD/DO

Mode (check one): ☐AC ☐SIMV ☐PSV

☐PRVC ☐BiPAP ☐Other:_____

Patient Sedated: ☐No ☐Induction ☐Maintenance

Patient Paralyzed: ☐No ☐Induction ☐Maintenance

ET Tube Size: _____ Depth: _____ @ Teeth/Lip

Respiratory Set Rate: _____ Actual Rate: _____

Tidal Volume (VT): _____

Fraction of Inspired Oxygen (FiO2): _____

Insp. Press/PS: _____ PEEP: _____

I:E ratio:_____ PIP: _____

SpO2: _____ ETCO2: _____

Additional Orders/ Comments:

Initial Transport Settings: to be filled out by EMS Provider

Mode (check one): ☐AC ☐SIMV ☐PSV

☐PRVC ☐BiPAP ☐Other:_____

Patient Sedated: ☐No ☐Induction ☐Maintenance

Patient Paralyzed: ☐No ☐Induction ☐Maintenance

ET Tube Size: _____ Depth: _____ @ Teeth/Lip

Respiratory Set Rate: _____ Actual Rate: _____

Tidal Volume (VT): _____

Fraction of Inspired Oxygen (FiO2): _____

Insp. Press/PS: _____ PEEP: _____

I:E ratio:_____ PIP: _____

SpO2: _____ ETCO2: _____

Our equipment is able to meet the above settings and I attest to my competency to operate this equipment during transport

_____
Paramedic Signature Date Time

This report was given by (print name): _____ RT / PA / NP / MD / DO

Signature: _____ Date : _____ Time: _____

This report was accepted by (EMT-Paramedic) Signature: _____ Date: _____ Time: _____

Original Copy: Sending Facility Copy 2: Accepting Facility Copy 3: Transport agency

BUREAU OF EMS AND TRAUMA
INTERFACILITY TRANSPORT FORM

Instructions for Completing 3485-ENG-DPH

Purpose: To record any drugs, devices and/or ventilator settings that may be required for patientcare during an interfacility transport.

Audience: The form will be completed by the sending facilities medical provider that is in charge of patient care. (RN / RT / PA / NP / MD / DO).

Instructions: Part A (Drug Report), Part B (Device Report) and Part C (Ventilator Settings) shall be completed as indicated, signed by the sending facility and attached to the EMS ePCR once transport is complete.

Office Mechanics & Filing: The form is filed with the agencies ePCR (electronic patient care report) and uploaded into the state database. It is maintained by retention schedule 10010 — Licensed Provider Files.