

## TRANSFER OF CARE SHEET

PATIENT/CALL INFORMATION							
Pt. Name:					Sex: M F		Age:
DOB:		Phone:			PMD:		
Address:							
Date:		1 <sup>st</sup> Resp Unit ID:		First Responder Name:			
Inc #:		Medic Unit ID #:		Transporting Medic Name:			
Call Location:				Care Transferred to:			
CHIEF COMPLAINT/SUMMARY							
VITALS							
TIME	HR	RR	BP	SPO2	ETCO2	EKG	BG
MEDICAL HISTORY							
Hx:							
Meds:							
Allergies:							
TREATMENT							
Time							
							Volume Infused:

**IMPORTANT:** This call information sheet is intended to assist in completion of an approved El Dorado County PCR and to be utilized as an interim PCR by receiving hospital personnel. Upon receipt of the official PCR this copy must be shredded by the receiving hospital staff. This protected health information is subject to all HIPAA requirements.