

<b>4 - TRANSPORT</b>	DESTINATION DETERMINED BY: <input type="checkbox"/> PATIENT <input type="checkbox"/> MD / DO / RN / PD <input type="checkbox"/> PROTOCOL / REGULATIONS <input type="checkbox"/> FAMILY <input type="checkbox"/> CLOSEST FACILITY	ALS AUTHORIZATION: <input type="checkbox"/> STANDING ORDERS <input type="checkbox"/> ON-LINE ORDERS  NAME OF MD / DO: _____	STRETCHER NECESSITY: <input type="checkbox"/> LIE FLAT <input type="checkbox"/> UNABLE TO SIT <input type="checkbox"/> UNABLE TO SIT 90° <input type="checkbox"/> NO SITTING BALANCE <input type="checkbox"/> BED CONFINED <input type="checkbox"/> TOTAL BED CARE <input type="checkbox"/> NEEDS ASSISTANCE	TRANSFERRED CARE TO: <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> NURSING HOME <input type="checkbox"/> HOME HEALTH SERVICES <input type="checkbox"/> FAMILY <input type="checkbox"/> SELF	PATIENT TRANSFERRED TO: <input type="checkbox"/> BED <input type="checkbox"/> STRETCHER <input type="checkbox"/> CHAIR <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> OTHER: _____
	POSITION PATIENT FOUND: <input type="checkbox"/> SEATED <input type="checkbox"/> SUPINE <input type="checkbox"/> PRONE <input type="checkbox"/> IN BED <input type="checkbox"/> ON STRETCHER <input type="checkbox"/> ON FLOOR <input type="checkbox"/> SEMI-FOWLERS <input type="checkbox"/> FULL FOWLERS <input type="checkbox"/> RECUMBENT:  LEFT                      RIGHT	POSITION PATIENT TRANSPORTED: <input type="checkbox"/> ON STRETCHER <input type="checkbox"/> SEATED <input type="checkbox"/> SUPINE <input type="checkbox"/> PRONE <input type="checkbox"/> SEMI-FOWLERS <input type="checkbox"/> FULL FOWLERS <input type="checkbox"/> RECUMBENT:  LEFT                      RIGHT	TRANSPORTATION (IMMOBILIZATION): <input type="checkbox"/> CERVICAL COLLAR / CID <input type="checkbox"/> KED <input type="checkbox"/> SHORT BOARD <input type="checkbox"/> LONG BOARD <input type="checkbox"/> STRETCHER <input type="checkbox"/> SCOOP <input type="checkbox"/> STAIR CHAIR <input type="checkbox"/> RIGID SPLINT <input type="checkbox"/> SLING / SWATH <input type="checkbox"/> HOT / COLD PACK		EMT PERSONAL PROTECTIVE EQUIPMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>5 - FACILITY TRANSFER INFO</b>	PICK-UP FACILITY & LOCATION:				
	RECEIVING FACILITY & LOCATION:				
	BLS TRANSFER EQUIPMENT NEEDED:		ALS TRANSFER EQUIPMENT NEEDED:		
	<input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> STAIR CHAIR <input type="checkbox"/> SCOOP STRETCHER <input type="checkbox"/> AMBULANCE STRETCHER	<input type="checkbox"/> RESTRAINTS <input type="checkbox"/> OXYGEN <input type="checkbox"/> HOSPITAL STAFF NEEDED <input type="checkbox"/> OTHER (list): _____	<input type="checkbox"/> ASSIST RESP VIA BVM <input type="checkbox"/> PULSE OXIMETRY <input type="checkbox"/> OXYGEN <input type="checkbox"/> CARDIAC MONITOR / DEFIB	<input type="checkbox"/> MEDICATION INFUSION PUMP(S) <input type="checkbox"/> ADDITIONAL HOSP STAFF <input type="checkbox"/> OTHER SPECIAL EQUIPMENT (list): _____	
<b>6 - NARRATIVE</b>					
	ATTACHED DOCUMENTATION? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO				
		PHYSICIAN (signature):	PHYSICIAN HOSPITAL AFFILIATION:		
RECEIVING NURSE / TRIAGE NURSE (print):		NURSE (signature):	HOSPITAL:		
NAME EMT (completed PCR):		EMT (signature):	EMT #:	EMPLOYEE #:	
NAME EMT:		EMT (signature):	EMT #:	EMPLOYEE #:	
NAME & EMT #:		NAME & EMT #:	NAME & EMT #:		