AMBULANCE TRANSPORT SUMMARY FORM

☐ *PATIENT IDENTIFICATION*

Patient's Name: _____Patient's Age: _____ Sponsor's Date of Birth:_____

Date of Request: _____Time of Request: _____

☐*SUMMARY OF TREATMENT RENDERED*

TREATMENT:_____

_____

ALLERGIES: _____

OUTPUT: _____ MONITOR (if applicable): _____

NEURO SIGNS (if applicable): _____

FOLEY: _____ NG: _____ IV Solutions: _____

RECORDS SENT: LAB _____ X-RAY_____ EKG_____ Nursing Notes_____

VITAL SIGNS (at time of transfer): T_____ P_____ R_____ BP_____/_____

☐*REASON FOR TRANSFER*

☐ Required medical services not available ☐ Bed not available

☐ Other _____

RECEIVING PHYSICIAN or PERSON CONTACTED: _____

RECEIVING FACILITY:_____

☐*PHYSICIAN'S CERTIFICATION* I have explained the following and certify that the benefits outweigh the risks:

The medical benefits of transfer are: _____

_____

The risks of transfer are: _____

_____

PHYSICIAN'S SIGNATURE:_____DATE:_____

☐*PATIENT'S CONSENT*

I have been advised of the noted benefits and risks derived from this transfer, and consent to the transfer.

PATIENT'S SIGNATURE:_____DATE:_____
(or responsible person)
RELATIONSHIP TO PATIENT:_____

☐*TRANSPORTATION*

COMPANY NAME:_____ARRIVED:_____DEPARTED:_____
(time) (time)

Reason contracted company not used:

NHCCHASN 6320/244 (Rev MAY/2013)

This information is protected by the Privacy Act of 1974 (PL-93-579) and
the Health Insurance Portability and Accountability Act (PL 104-191)