Central New York Emergency Medical Services
Interfacility Transfer Document

Patient Name: _____ Date of Birth: ____/____/____

Diagnosis: _____Condition: stable_____ unstable_____

Agency: _____ Hospital Origin: _____ Hospital Destination:_____

PHYSICIANS: This area must be completed for all transfer medications, PRIOR to transport by EMS. Thank you.

Check all that apply.

_____**Intravenous Fluids:** Fluid:_____Infusion Rate:_____

_____**Medication – Continuous Infusion**

Medication ordered: _____

Infusion Rate: _____

Parameters:

Vital signs:

Maintain BP above_____and below _____

Pain: as tolerated

Other:_____

_____ **Medication – PRN**

Medication ordered: _____

Dose: _____ Frequency: _____

Route: IV push: _____ IM _____SQ_____Other _____

Parameters:

Vital signs:

Maintain BP above_____and below_____

Pain: as tolerated

Other: _____

Ordering Physician: Name _____

Print Signature

Date: ____/____/____ Time: _____

EMS Use ONLY

Provider: _____

Printed Name Signature AEMT #

Date: ____/____/____ Time: _____

PCR #: _____

CNYEMS Use ONLY

Date Received: _____ Date Reviewed:____/____/____

QA Done by: _____