Gold Cross Ambulance Service, Inc.
Fax – 920.967.6077 Dispatch – 920.727.3034 Toll Free – 888.888.3838

Inter-facility Transport Requirements Packet
Cover Sheet

Please complete all items on this document and in the packet to promote a more efficient and successful transfer/transport of the patient.

Worksheets in this packet:
✓ Inter-facility Transport Requirements Worksheet
✓ Interfacility Transfer Guidelines and Expectations
✓ SBAR – Transfer Document (BLS/I/ALS/CCT/ACCT)
✓ Physician Certification Statement Worksheet
✓ Patient Signature Form (HIPPA Document)

Required Documents – Complete and Fax to Gold Cross Ambulance Dispatch:
☐ Inter-facility Transport Requirements Worksheet
☐ Recent and updated patient face sheet
☐ Physician Certification Statement (PCS) Worksheet

Required Documents – Complete and Hand to the Ambulance Crew upon their arrival:
☐ Recent and updated patient face sheet
☐ Physician Certification Statement (PCS) Worksheet
☐ Completed SBAR – Transfer Document
☐ Patient Summary of current hospital stay
☐ Inter-facility Transport Requirements Packet Cover Sheet (this sheet)

Requested Documents – Or complete the SBAR worksheet appropriately
☐ Patient H&P/Summary (at least from most current encounter)
☐ Current lab results
☐ Medication Administration Record (MAR)
☐ Current EKG (as appropriate)
☐ Patient signature form (if able – have patient or family (if patient unable) sign document)
☐ Other documents, as appropriate

Nurse/Case Manager Signature: ________________________________ Date: ____________

*Please complete the Inter-facility Transport Requirements Worksheet as accurate as possible, add comments as needed. The more accurate it is, the more appropriate EMS provider level will be sent. Questions contact dispatch. Thank you for your time with completing these important documents/requirements.
**Inter-facility Transport Requirements Worksheet**

Please complete this form and fax with a recent patient face sheet and Physician Certification Statement. If you are not contacted within 20 minutes of faxing this, please call Gold Cross Dispatch.

**Ambulance crew will also request these sheets upon arrival to patient side.**

***May call you for further information, please list appropriate contact info.***

**CALL GOLD CROSS DISPATCH IMMEDIATELY IF CODE CARDIAC OR CODE STEMI!**

NOTE: If this patient has Medicaid/Medical Assistance, and being transported from the floor, the hospital must call MTM prior to transportation. (MTM – 866.907.1497) **This does NOT apply to ER transports.**

**PLEASE PRINT LEGIBLY – HIGHLIGHTED PORTIONS ARE REQUIRED**

<table>
<thead>
<tr>
<th>Contact Person / Phone #</th>
<th>Date of Transport</th>
<th>Time of Transport (or ASAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Date of Birth</th>
<th>Patient Weight</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>___ kg ___ lbs.</td>
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</tbody>
</table>

Sending Facility: __________________________________ Location/Room Number: __________________
Receiving Facility: _______________________________ Location/Room Number: __________________

**Medical Reason For Transport (Document more specifics on Physician Certification Statement)**

<table>
<thead>
<tr>
<th>Equipment Necessary</th>
<th>Precautions/Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Oxygen ________ Mode</td>
<td>□ Isolations</td>
</tr>
<tr>
<td>□ Ventilator Mode ________ BiPAP CPAP</td>
<td>□ Precautions</td>
</tr>
<tr>
<td>□ IV YES NO (circle one) Central Line/ PICC/ Port</td>
<td></td>
</tr>
<tr>
<td>□ # of IV(s) ___</td>
<td></td>
</tr>
<tr>
<td>□ Invasive lines (circle appropriately)</td>
<td></td>
</tr>
<tr>
<td>ART CVP SWAN-GANZ ICP</td>
<td></td>
</tr>
<tr>
<td>□ Medication(s) infusing YES NO (circle one)</td>
<td></td>
</tr>
<tr>
<td>□ # of medication drips ______________</td>
<td></td>
</tr>
<tr>
<td>□ # of non-medication drips ___</td>
<td></td>
</tr>
<tr>
<td>□ Blood Products YES NO (circle one) PRBC FFP PLTs Cryo</td>
<td></td>
</tr>
<tr>
<td>□ # of Blood Products ______</td>
<td></td>
</tr>
<tr>
<td>□ Initiate during transport YES NO (circle one)</td>
<td></td>
</tr>
<tr>
<td>□ Cardiac Monitor YES NO (circle one)</td>
<td></td>
</tr>
<tr>
<td>□ Drains (circle appropriately)</td>
<td></td>
</tr>
<tr>
<td>NG/OG Chest Tube FOLEY Other</td>
<td></td>
</tr>
<tr>
<td>□ Drains to Suction YES NO (circle one)</td>
<td></td>
</tr>
<tr>
<td>□ Isolations</td>
<td></td>
</tr>
<tr>
<td>□ Precautions</td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous Supplies/Equipment</strong></td>
<td></td>
</tr>
<tr>
<td>□ Additional Information/Requests/Orders</td>
<td></td>
</tr>
</tbody>
</table>

**Request:** BLS I ACLS CCT ACCT
**Request:** Critical Care Team
□ One family/friend request to come? YES NO

Comments __________________________________________

Updated 1.2019
Gold Cross Ambulance provides interfacility transfers for the following:

It is the responsibility of the transferring physician to choose the most appropriate mode of transport/level of care if a question arises.

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1 EMT/AEMT w/ patient</td>
<td>1 Paramedic w/ Patient</td>
<td>1-Paramedic w/ Patient</td>
<td>1-CC-Paramedic/RN w/ Patient</td>
<td>2-CC-Paramedics/RN and 1- Driver w/Patient</td>
</tr>
<tr>
<td>EMT/AEMT w/ Paramedic</td>
<td>EMT/AEMT w/ Paramedic</td>
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</table>

**AIRWAY/VENTILATION/OXYGEN**

- Basic airway and O2 devices as defined by “WI EMS Scope of Practice Guidelines”
- Basic & Advanced airway & O2 devices as defined by “WI EMS Scope of Practice Guidelines”
- □ RSI
- □ Variable Setting Ventilator
- □ Chest tube w/ suction
- □ BiPAP
- □ Need for airway management
- □ Vent w/ > 2 medicated drips
- □ Vent w/ severe burn patients
- □ Need for airway management
- □ Risk for airway deterioration
- □ Acute pulmonary failure
- □ Advance pulmonary care
- □ Surgical emergency (e.g. Aortic Dissection/Anuerysm)

**CARDIOVASCULAR/CIRCULATION**

- No cardiac monitoring capabilities
- ECG Monitor / 12 Lead
- ECG Monitor/12-lead Defibrillation/Cardioversion Transcutaneous Pacing Blood product monitoring
- Arterial Line Monitoring Blood/Blood Product Initiation
- CVP Line Monitoring Swan-Ganz Catheter Monitoring
- Transvenous Pacing maintenance & troubleshooting
- Unstable trauma with need for multiple units of blood products
  - ECMO and Balloon Pump patients (require sending facility RN to accompany)
  - Requires continues IV vasoactive medications or mechanical assistance to maintain cardiac output

**MEDICATION ROUTES**

- PO, SL, SQ, IM Aerosol/Neb, Non-Medicated IV Fluids (AEMT)
- Same as BLS
- BLS Route plus ETT (short transfers), SQ/IM/IO/PO/PR/SL, IV with medicated drips up to 2 medicated drips
- ALS plus Central Line-use/maintenance > 2 medicated drips Use/maintenance of ports
- All CCT, ALS, and BLS routes

**MISCELLANEOUS INFORMATION**

- Cannot take blood products, vent transports, medicated drips, or chest tube patients.
- Same as BLS
- Cannot RSI, take ventilators, BiPAP, or > 2 medicated drips. Non-medicated drips are not counted as “medicated drips”
- CCT team always has the capacity to request a driver if they determine patient needs require 2 providers w/patient
- Cannot take ECMO, Balloon Pump, NICU or High Risk OB without sending facility RN/MD.
- Sending physician may elect to send additional staff with CCT if deemed appropriate.

For all interfacility transfers, required documents that are to be supplied to the crew:

- Recent updated patient face sheet
- Physician certification statement (PCS)
- Patient signature sheet (as applicable)

**Requested information:** (may be written on SBAR document or printed and handed to crew)

- Completed SBAR document; Medical history and/or most recent H&P (from current encounter)
- Laboratory values, current EKG, MAR - from current encounter and/or previous 12-24 hours
- Patient summary (of current encounter)
**Completion this will assist in decreased scene time and promote a more efficient transfer/transport**

### Situation

- **Patient Name:** ________________________________  
- **D.O.B.:** __________________
- **Code Status:** Full  DNR  DNI  
- **Age:** ______  
- **Weight:** _____lbs _____kg
- **Diagnosis:** ____________________________________________________________
- **Reason for Admission/Transfer:** _________________________________________
- **Cause of Injury/Medical Illness:** _________________________________________
- **Isolation/Precautions:** _________________________________________________
- **Current Mental Status:** ____________________  
  **Normal Mental Status:** ____________

### Background

- **History:** ____________________________
- **Medication(s):** ________________________________________________________
- **Allergies:** ____________________________________________________________
- **Medication(s)/Fluid(s) Given (Include IV/PO and Infusion(s))(Name/Dose/Time):**
  - □ _____________________________   □  ___________________________________
  - □ _____________________________   □  ___________________________________
  - □ _____________________________   □  ___________________________________
- **Procedures Completed:** ________________________________________________
- **Blood Work:** _________________________________________________________
- **ABG**  
  - **pH**____  
  - **PCO₂**____     
  - **HCO₃**____     
  - **PaO₂**_____ if on FiO₂ ____%

### Assessment

- **Vascular Access(es):** __________________________________________________
- **IV Fluid(s)/Medication Infusion(s):** **Name/Dose/Rate**
  - □ _____________________________   □  ___________________________________
  - □ _____________________________   □  ___________________________________
  - □ _____________________________   □  ___________________________________
- **Invasive Line(s):** ART  location________________  Other __________________
- **Blood Products:** YES  NO  
- **Initiate During Transport:** YES  NO  
- **Rate:** __________  
- **Cardiac Monitor:** YES  NO  
- **Rhythm:** ______________________________________
- **Drains:** NG/OG  Chest Tube  Foley  Other__________To Suction: YES  NO  
- **Most Recent Vitals:**
  - **BP**____/____ Reg Irreg  Temp ___°F
  - **RR**____ Reg Irreg  SpO₂______% RA or O₂____ lpm  EtCO₂______
  - **O₂____ Mode** Ventilator BiPAP  CPAP  Mode __________
  - **Vent:** FiO₂____ PEEP_____ PIP_____ RR____  Vt______
  - **IPAP/EPAP_____ I:E_____**

### Recommendation

- **Receiving Facility:** ________________________________  
  **Room:** ________________
- **Orders for Transport:** _______________________________________________
- **Comments:** ___________________________________________________________