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.*

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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**

Contact Person / Phone #	Date of Transport	Time of Transport (or ASAP)

Patient Name	Patient Date of Birth	Patient Weight
		_____ kg _____ lbs.

Sending Facility: _____ **Location/Room Number**: _____
Receiving Facility: _____ **Location/Room Number**: _____

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

Equipment Necessary	Precautions/Isolation
□ **Oxygen** _____ Mode _____ □ **Ventilator** Mode _____ BiPAP CPAP □ **IV** YES NO *(circle one)* **Central Line/ PICC/ Port** □ # of IV(s) _____ □ **Invasive lines** (*circle appropriately)* ART CVP SWAN-GANZ ICP □ **Medication(s) infusing** YES NO *(circle one)* □ # of medication drips _____ □ # of non-medication drips _____ □ **Blood Products** YES NO *(circle one)* *PRBC FFP PLTs Cryo Whole Blood* □ # of Blood Products _____ □ Initiate during transport YES NO *(circle one)* □ **Cardiac** Monitor YES NO *(circle one)* □ **Drains** (*circle appropriately)* *NG/OG Chest Tube FOLEY Other* _____ □ **Drains to Suction** YES NO *(circle one)*	□ Isolations _____ □ Precautions _____ **Miscellaneous Supplies/Equipment** □ _____ □ _____ _____ □ Additional Information/Requests/Orders _____ _____ _____ _____ □ ***Request:*** BLS I ACLS CCT ACCT □ ***Request****: Critical Care Team* □ One family/friend request to come? YES NO Comments _____ _____

BLS / I / ALS / CCT / ACCT

Interfacility Transfer Guidelines and Expectations

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.

Basic Life Support (BLS): 1 EMT/AEMT w/ patient EMT/AEMT w/ Paramedic	**Intermediate (I):** 1 Paramedic w/ Patient EMT/AEMT w/ Paramedic	**Advanced Life Support (ALS):** 1-Paramedic w/ Patient	**Critical Care Transport (CCT):** 1-CC-Paramedic/RN w/ Patient	**Advanced Critical Care Transport (ACCT):** 2-CC-Paramedics/RN and 1-Driver w/Patient ***Any pediatric pt that meets CCT criteria***
AIRWAY/VENTILATION/OXYGEN				
Basic airway and O2 devices as defined by "WI EMS Scope of Practice Guidelines	Same as *BLS*	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)

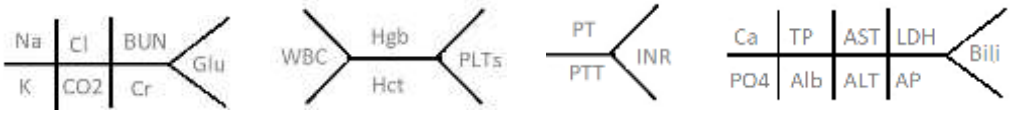
Requested information: *(may be written on SBAR document or printed and handed to crew)*

- □ 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)*

Gold Cross Ambulance Service, Inc.
Expert Care in a Heartbeat

BLS / I / ALS / CCT /ACCT
SBAR - Transfer Document

Completing this will assist in decreased scene time and promote a more efficient transfer/transport

S ***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:** _____
B ***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*_____ *PCO_2* ____ *HCO_3* _____ *PaO_2* _____ *if on $FiO2$* ____%  **RSI:** ***Time*** _____ ***Med(s) Given (Dose/Time): Sedation*** _____ ***Paralytic*** _____ **ETT**: *Size* _____*/ Cuffed:YES NO / @ Teeth* ____ *cm*
A ***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* _____/_____ *HR* _____ *Reg Irreg Temp* ____*F* *RR* _____ *Reg Irreg SpO2* _____% *RA or O_2* ____ *lpm $EtCO_2$* _____ **O_2** _____ **Mode** _____ **Ventilator** *BiPAP CPAP Mode* _____ **Vent:** *FiO_2* _____ *PEEP* _____ *PIP* _____ *RR* _____ *Vt* _____ *IPAP/EPAP* _____ *I:E* _____
R ***Recommendation***	**Receiving Facility:** _____ **Room:** _____ **Orders for Transport:** _____ _____ **Comments:** _____ _____ _____ _____