Marin County EMS

Pre-Hospital Field Transfer Form (FTF)

Last Name _____ First Name _____ Age _____ DOB _____ M F

Date _____/_____/_____ Pt. Transferred Time_____ Unit #_____ Incident # _____

Pt. Address _____Phone (____)_____ PMD_____ Ins. ID #_____

Incident Address _____❑PT's HOME ❑SNF ❑ASSISTED LIVING ❑OTHER _____

Facility - Name _____ Contact Person_____ Phone _____

Code Status Information: ❑Full ❑POLST Form ❑DNR Form ❑Hospice - Agency _____ Phone_____
Person best able to provide
history about current illness: ❑Patient ❑Facility ❑Other: Name _____ Phone_____

(M) Chief Complaint _____

_____

_____

Signs & Symptoms _____

_____

_____

Medical History_____

_____

_____

_____

Medications _____

_____

_____

_____

_____

_____

Allergies_____

_____

✓ = WNL (I) PHYSICAL EXAM

❑ Head_____

❑ Pupils_____

❑ Neck _____

❑ Chest_____

❑ Abdomen _____

❑ Back _____

❑ Pelvis _____

❑ Extremities _____

Time	(T) Treatment	Response

(V) Time	Position	BP	Pulse	RR	SpO_2	BGL	Temp	Pain (# / 10)	GCS	ECG
		/								
		/								
		/								

Notes

E	Spon 4	Voice 3	Pain 2	None 1		
V	Orient 5	Con 4	Innap 3	Incomp 2	None 1	
M	Obey 6	Local 5	Withdrl 4	Flex 3	Exten 2	None 1

Lead Medic

Signature