

Ambulance Trip Sheet

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|-----------------------------------|-------|------------------|-----------------------------------|--------------------------------|
| Call Number | Date | Dispatch# | Patient Name SSN# | Page: History ID Issued on: |
| PCR# | | | | |
| Patient Information | | | | |
| Name: | | Gender: | | Provider Impression: |
| Title: | | Phone: | | |
| SSN: | | | | |
| Address: | | | Chief Complaint: | |
| Gender: | | Weight: | | Date of Birth: |
| | | | | Age: |
| Secondary Complaint: | | | | |
| Incident# | | Medical Record # | | Family Physician: |
| Phone # | | | | |
| Call Information | | | | |
| Provider: | | | Pickup Location: | |
| Unit # | | | Address 1: | |
| Onset Time: | | | Address 2: | |
| Patient Disposition: | | | City, ST, Zip: | |
| Disp: Urgency: | | | Latitude: | Longitude: |
| Mode to Scene: | | | Drop off Location: | |
| Mode From Scene: | | | Destination Determination: | |
| Transportation Agency: | | | Loaded Mileage: | Total Mileage: |
| Transporting Unit: | | | Starting: | Pick Up: |
| Ord/Ref Doctor: | | | Drop off Patient: | Ending: |
| Dispatch Reason: | | | How Patient Moved To Ambulance: | |
| Patient Pos During Tran: | | | How Patient Moved From Ambulance: | |
| Mutual Aide: | | | Patient Condition at Destination: | |
| Pertinent Findings | | | | |
| Level of Care: | | | Cause of Injury: | |
| Alcohol/Drug Use Indicators: | | | | |
| Special Scene Factors: | | | | |
| Primary Signs and Symptoms: | | | | |
| Current Medications: | | | | |
| List with Patient: | | | | |
| Envir./Food Allergies: | | | | |
| Medication Allergies: | | | | |
| NKDA: | | | | |
| Past Medical History: | | | | |
| Medical/Surgical | | | | |
| AMS GERD HTN ANEMIA HYPERGLYCEMIA | | | | |
| Event Chronology | | | | |
| TIME | EVENT | ATTENDANT | EVENT | |
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| Call Number: | Date: | Dispatch # | Patient Name: SSN# | Page History ID |

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|---------------------------------|----------------------------------|--|---|
| | | | Issued On |
| Narrative: | | | |
| Additional Crew Members: | | | |
| Driver | Primary Patient Caregiver | | Transfer Care to |
| | | | |
| EMT Paramedic | EMT Paramedic | | I certify the above name patient was received by our facility on this date and time set forth in this report. |
| Patient Signature | Med. Direction Authorized by: | | |
| | | | |
| | | | |

Please note: Completion of this form, in its entirety, is required upon submission to BCBSNC. Incomplete forms will result in delayed processing.