EMS Run Number: _____

North East
Mobile Health Services

Paramedic Inter-Facility Transport Order Form

Date:	
Time:	

PT Name:	
PT DOB:	
PT MRN:	

Sending Hospital:
Sending Physician:
Sending Dept. Contact #:
Accepting Hospital:
Accepting Physician:
Accepting Dept. Contact #:

PT Allergies:	

Procedure Orders:

- ☐ Chest tube to gravity
- ☐ Chest tube to suction _____cmH20
- ☐ Deep suctioning
- ☐ Serial EKGs (12-lead)
- ☐ Serial Vital Signs q _____ min.
- ☐ _____
- ☐ _____

Additional Staffing Requirements per MEMS PIFT Program Guidelines:

- ☐ Respiratory Therapist (RT)
- ☐ Nurse (RN)
- ☐ Nurse Practitioner (NP)
- ☐ Physician Assistant (PA)
- ☐ Physician
- ☐ Additional Paramedic(s)

Medication (Push-Dose):

- ☐ Ondansetron IVP at _____ mg, q _____ min.
- ☐ Fentanyl IVP at _____ mcg, q _____ min.
- ☐ Midazolam IVP at _____ mg, q _____ min.
- ☐ Metoprolol IVP at _____ mg, q _____ min.
- ☐ _____
- ☐ _____

Medication (Drips):

- ☐ IV fluid at _____ ml/hr of _____
- ☐ Nitro drip at _____ mcg/min at _____ ml/hr
- ☐ Heparin drip at _____ units/hr at _____ ml/hr
- ☐ Dopamine drip at _____ mcg/kg/min
- ☐ _____
- ☐ _____

Other Medical Orders:

- ☐ _____
- ☐ _____

Signature of Physician or Authorized Healthcare Professional

Printed Name of Physician or Healthcare Professional: _____

Signature of Physician or Healthcare Professional: _____

In the rare instance you are unable to obtain the signature of the sending physician, the following authorized healthcare providers, who have been involved in the patient's care, may sign this form on behalf of the physician verifying that these orders were placed by the physician, but should not be routine practice. Please also include a copy of the original physician order with this from. (please check the appropriate box):

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Registered Nurse