Ambulance Trip Sheet

Call Number	Date	Dispatch#	Patient Name SSN#	Page: History ID Issued on:

PCR#	Patient Information
Name: Gender: Title: SSN: Phone:	Provider Impression:
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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				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.