

Ambulance Trip Sheet

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	
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.