TRANSFER OF PATIENT CARE:

I acknowledge that the below patient was transferred to my care.

Patient Name: ____________________________________ EMS Medical Record #: _____________

Patient Date of Birth: ______________________

Date/Time of Transfer of Care: ____

Transferring Agency: ____

Receiving Agency/Facility: ____

Signature of Person Receiving Patient:

Printed Name: _____________________________________ Title: ____________________

Signature Date: ________________

Witness Signature & Title: ____

SOUTH DAKOTA DEPARTMENT OF HEALTH