Re-Triage/Emergent/Urgent Transfer Guidelines
City and County of San Francisco
EMSAC JULY 2025

Table 1: EMS Scope of Practice

Level of Care	Staff	Patient Type	Scope of Practice Includes*
Basic Life Support (BLS)	EMT	Stable *(E.g. 4 rib fracture on 4L NC O_2)*	• IV locked • O2 cannula or mask • Equipment: nasogastric tube, gastric tube, foley catheter, patient-controlled device (e.g. insulin pump)
Advanced Life Support (ALS) Paramedic	Paramedic	Stable *(E.g. non-emergent cardiac cath lab)*	• IV fluids (e.g. LR/NS, blood started in ED) • CPAP. No ventilator. • Cardiac monitoring • Equipment: chest tube water seal, arterial line capped • Medications: all meds permitted in local scope of practice *except no* IV pump infusion
Critical Care (CCT –RN or CCT- CP)	CCT-RN CCT-P	Stabilized May need blood pressure and respiratory, monitoring and support *(E.g. intracranial hemorrhage on clevidipine drip)*	• Intubated stable ventilator settings, BIPAP, high flow • Cardiac monitoring, blood pressure monitoring • Equipment (CCT-RN only): transvenous pacer, arterial line, intracranial pressure line, mechanical circulatory support (Impella®, Intra-aortic balloon pump, ECMO) • Medications: titratable IV medications
9-1-1 Advanced Life Support (ALS)	Paramedic	Same scope of practice as ALS above Patient type: stabilized patient with time sensitive emergency requiring definitive treatment. • Includes: Emergent Trauma • ‡May include: STEMI Activation, Stroke/LVO, OB emergency	

* If medications /interventions exceed the EMS scope of practice an extended service provider (MD/NP/PA/RN) must accompany the patient.
‡ 9-1-1 EMS resources are **only** indicated when appropriate interfacility transportation is not available quickly enough for a time sensitive emergency.

Sending Physician responsibilities:

- Provide medical screening exam and treatment to stabilize patient prior to transfer.
- Maintain responsibility for determination of patient stability and clinical appropriateness for transfer.
- Confirm receiving hospital has space, resources available and accepting qualified physician.
- Certify that the patient understands the risk and benefits of transfer or in cases of emergency transfer, the benefits of a transfer outweigh the risks.
- Assure that an appropriate vehicle, equipment and level of personnel is used in the transfer.
- Anticipate patient's needs during transport if clinical deterioration occurs.
- Provide detailed patient care instructions to EMS personnel appropriate to their scope of practice and patient condition (see Table 1). This may include blood pressure parameters, patient positioning etc.
- If possible, send the patient's medical record (including medications administered, relevant pertinent diagnostic tests, DNR forms etc.) and personal belongings with the patient

Re-Triage/Emergent/Urgent Transfer Guidelines
City and County of San Francisco
EMSAC JULY 2025

Table 2: Urgent Versus Emergent Trauma

	TRAUMA RE-TRIAGE/EMERGENT	URGENT TRAUMA TRANSFER REQUEST	URGENT TRAUMA SPECIALTY FOLLOWUP
Procedure	1. Provide immediate lifesaving interventions (airway management, hemorrhage control, decompress tension pneumothorax, etc.) 2. Call 9-1-1 and request an EMERGENCY RESPONSE ~~3.~~ Call ZSFGH at (628)206-8111 to notify the ED Attending in Charge (AIC) 4. If possible, send the patient's medical record (e.g. paramedic records, emergency department records, images, lab tests) with the patient but this should not delay transport. Delayed records must be faxed to BOTH: a. ZSFG Emergency Dept at (628) 206-9176. b. ZSFG Trauma Services Administration at (415) 206-4079	1. Call SFGH at (628)206-8111 and discuss with ED Attending in Charge (AIC) patient status. 2. These patients may require additional diagnostic procedures to evaluate injuries prior to transfer acceptance. 3. If transfer accepted, arrange for transport appropriate to patient's condition according to EMS Scope of Practice 4. Prepare patient records and results of any imaging studies and send with the patient.	1. Follow local specialty outpatient referral processes to establish patient follow-up.
Example Criteria (May include but are not limited to)	High likelihood for emergent life or limb-saving surgery or other intervention within two (2) hours. Meet prehospital trauma activation criteria (Policy 5001) Examples: Penetrating injury to head, neck chest or abdomen, extremity injury with evidence of ischemia or loss of pulses, all blunt trauma with suspected significant chest, abdominal or pelvic injury flail chest; burns with trauma; two or more proximal long bone injuries; pelvic fractures; limb paralysis; amputation proximal to wrist or ankle; crushed, degloved, or mangled extremity; extremity injury with ischemia evident or loss of pulses; open / depressed skull fracture, spinal cord injury, multi-system trauma.	• Intracranial hemorrhage • > 3 or more rib fractures and/or pulmonary contusion with significant oxygen requirement • Solid organ injury confirmed by U/S or CT scan • 2 or more long bone fractures; suspected crush injury or compartment syndrome • Any pregnant trauma patients (>20 weeks).	• Uncomplicated tympanic membrane perforation • Nasal fracture without septal hematoma • Isolated closed extremity fracture • Blunt periocular trauma without acute vision loss