

**MEDICAL RECORD**

**Patient Transport Request & Orders**

DATE AND TIME			ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP	Rx			
		1.	Transfer From: <input type="checkbox"/> -ED <input type="checkbox"/> -ICU <input type="checkbox"/> -4OB <input type="checkbox"/> -NSY <input type="checkbox"/> -MS5 Transferring Physician Name & Phone: _____		
		2.	Transfer To : _____ Unit : _____ Accepting Physician Name & Phone : _____		
		3.	Type of Transfer Requested: <input type="checkbox"/> - ALS <input type="checkbox"/> -BLS <b>AND</b> <input type="checkbox"/> -Ground <input type="checkbox"/> -Air		
		4.	<b>Patient Information:</b> <input type="checkbox"/> -Male <input type="checkbox"/> -Female Age: _____ <input type="checkbox"/> -Adult <input type="checkbox"/> -Child <input type="checkbox"/> -Newborn HT: _____ WT: _____ Status: <input type="checkbox"/> -Active Duty <input type="checkbox"/> -Dependent <input type="checkbox"/> -Retired <input type="checkbox"/> -Civilian Diagnosis: 1) _____ 2) _____ Drug Allergies: <input type="checkbox"/> -NKDA <b>OR</b> (list): _____		
		5.	Transport:: <input type="checkbox"/> -Supine <input type="checkbox"/> -Semi-Fowlers <input type="checkbox"/> -Prone <input type="checkbox"/> -On Right Side <input type="checkbox"/> -On Left Side		
		6.	<b>Oxygen Needs:</b> <input type="checkbox"/> -Room Air <input type="checkbox"/> -O <sub>2</sub> Via <input type="checkbox"/> -Nasal Cannula <input type="checkbox"/> -Face Mask @ _____ L/min <input type="checkbox"/> -Intubated (Oral, Nasal] <input type="checkbox"/> -Trach (Size: _____ ) (CIRCLE) Vent Settings: Mode: _____ FIO <sub>2</sub> : _____ % Rate: _____ Tidal Vol: _____ Keep SaO <sub>2</sub> Range: _____ %		
		7.	<b>Lines, IVF and Drips:</b> <input type="checkbox"/> -Peripheral IVs X _____ (List Locations): _____ _____ <input type="checkbox"/> -PICC (Location): _____ <input type="checkbox"/> -Central Line (Location): _____ <input type="checkbox"/> -A-Line (Location): _____ <input type="checkbox"/> -IV Pumps IVF, Drips and Rate: a) _____ b) _____		
		8.	<b>Other Needs:</b> Monitors: <input type="checkbox"/> -Cardiac <input type="checkbox"/> -Fetal <input type="checkbox"/> -Pulse Ox <input type="checkbox"/> -Pacemaker (Type): _____ <input type="checkbox"/> -Foley <input type="checkbox"/> -NG Tube <input type="checkbox"/> -Suction <input type="checkbox"/> -Chest Tube (S) (Location & Drainage): _____ <input type="checkbox"/> - Drains (List): _____ <input type="checkbox"/> -Restraints <input type="checkbox"/> -C-Spine Caution <input type="checkbox"/> -Isolation Cautions (Be Specific): _____		

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		9.	Medications: <i>(List Drug/Dose/Route &amp; Time Of Last Dose)</i> a) _____ c) _____ b) _____ d) _____		
		10.	Paralytic Used? <input type="checkbox"/> -Yes <input type="checkbox"/> -No <i>(List Drug/Amount &amp; Time Given):</i> _____		
		11.	<b><u>Special Information:</u></b> <b><u>Obstetrical:</u></b> <input type="checkbox"/> -N/A Gravida: _____ Para: _____ Gestational Age: _____ Weeks SROM?: <input type="checkbox"/> -Yes <input type="checkbox"/> -No Active Labor: <input type="checkbox"/> -Yes <input type="checkbox"/> - No Contractions: _____/Min Dilation: _____ Cm Effacement: _____ % Tocolytic: <input type="checkbox"/> -None Or <i>(List):</i> _____ Bleeding: <input type="checkbox"/> -Yes <input type="checkbox"/> -No EBL Amount: _____ Hct: _____ Blood Needed OR Infusing During Transport: <input type="checkbox"/> -Yes <input type="checkbox"/> -No		
		12.	<b><u>Special Information:</u></b> <b><u>Neonatal:</u></b> <input type="checkbox"/> -N/A Gestational Age: _____ Wks Delivery Date / Time: _____ <input type="checkbox"/> -Vaginal <input type="checkbox"/> -C-Section Weight In Grams: _____ Apgars: _____ / _____ Other: _____		
		13.	<b><u>Physicians:</u></b> Identify Records to Go With Patient: <i>(check all applicable)</i> <input type="checkbox"/> -Orders <input type="checkbox"/> -H&P / ETR <input type="checkbox"/> -Progress Notes <input type="checkbox"/> -Labs <input type="checkbox"/> -X-ray <input type="checkbox"/> -EKG <input type="checkbox"/> -Other: _____ <b><u>Nursing Staff:</u></b> Confirm and Verify Records Leaving With Patient <input type="checkbox"/> -Orders <input type="checkbox"/> -H&P / ETR <input type="checkbox"/> -Progress Notes <input type="checkbox"/> -Labs <input type="checkbox"/> -X-RAY <input type="checkbox"/> -EKG <input type="checkbox"/> -Other: _____		
		14.	Other: <input type="checkbox"/> -N/A a) _____ b) _____		
		15.	<b>FAX TRANSPORT REQUEST/ORDERS TO NHB SECURITY (360) 475-4577</b>		
		16.	PHONCON TRANSFERRING & ACCEPTING PHYSICIAN DATE/TIME: _____		
		17.	TRANSFER PHYSICIAN SIGNATURE:		