PATIENT ASSESSMENT

Diagnosis

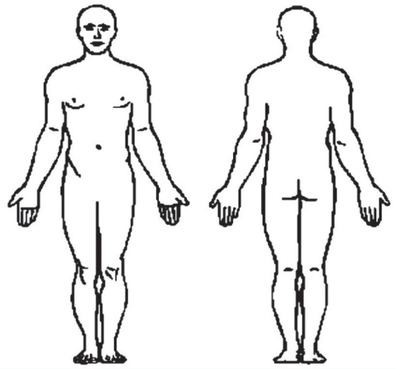
Diagnosis

Diagnosis

Reason for Transfer

SOFA Score

Relevant PMHX:



Allergies

Respiratory

CVS

CNS

Renal / metabolic

GIT

Haematological

Sepsis

	Date of Insertion	Details: Size, Site
Endotracheal Tube / tracheostomy		Size: At lips: cms Secured: Y/N
Spontaneous		
Settings charted		
Chest Drains		Drain (D) Heimlich (H)
		Left / Right/ Bilateral
Central Venous Access		
Arterial line		
Peripheral Access		Size: Site: Size: Site: Size: Site:
Other		
Dialysis access site	Date of most recent dialysis	Site of fistula:
CT Scan		
Mannitol given		
NG / OG		
Urinary catheter		

Comments

UNTOWARD EVENTS (PLEASE TICK)

Identify all critical incidents during transit (tick all that apply)

- ☐ No untoward events
- ☐ Accidental Extubation
- ☐ Intubationin transit required
- ☐ HR>120bpm (> 1 min absence of rationale)
- ☐ SBP < 80mmHg (> 1 min absence of rationale)
- ☐ Cardiac Arrest
- ☐ No IV access on arrival
- ☐ Loss of Oxygen supply
- ☐ Vehicle breakdown
- ☐ Injury to staff
- ☐ Nature of injury
- ☐ Occupational health / incident report
- ☐ Ambulance failure
- ☐ Monitor failure
- ☐ SaO2 < 90% (> 1 min absence of rationale)
- ☐ HR < 40 bpm (> 1 min absence of rationale
- ☐ SBP > 180 mmHg (> 1 min absence of rationale
- ☐ Patient died
- ☐ Organisational failure
- ☐ Ventilator failure
- ☐ Pump failure
- ☐ O2 supply failure
- ☐ Vehicle accident
- ☐ Incident report Y/ N
- ☐ Staff Number:

Retrieval Team

Patients Name: DOB: Number: A

National Transport Medicine Programme
• NEONATAL • PAEDIATRIC • ADULT

Adult Critical Care Transport Record

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

REFERRAL

Time and Date of Referral / Retrieval Service: Time HH MM Date DD MM YYYY

Family Name First Names

Date of Birth DD MM YYYY Weight kgs Height MRN Gender: Male Female

Referring Hospital

From (Unit) Tel

ICU Consultant

Referring Specialty

Referring Consultant

Contact No.

Receiving Hospital

To (Unit) Tel

ICU Consultant

Receiving Specialty

Receiving Consultant

Contact No.

Specialist Team: Unable to contact Contact Number

Discussed with by Referring Team Receiving Team Retrieval Team

Reason for Referral transfer: No ICU Specialist treatment Increased level of care No ICU bed available

Transferred from ICU HDU OT ED Ward other

Transferred to ICU HDU OT ED Ward other

Intubated Yes No Inotropic support Yes No IABP Yes No ECMO Yes No

Repatriation Other

Days in ITU Date of Primary Admission DD MM YYYY Days in hospital

Infection risk Yes No Isolation Required Yes No

MRSA C Diff VRE CRE Other

Next of kin Data

Name Relationship Tel No

NOK given Name of Hospital/Unit Yes No Aware of transfer Yes No

GROUND TRANSPORT METRICS

Ambulance	Ambulance called at HH MM		Departed hospital at HH MM	
Referring Hosp	Arrived at: HH MM		Departed at HH MM	
Receiving Hosp	Arrived at: HH MM		Departed at HH MM	

HELICOPTER

NACC Desk Contacted at		HH MM	Referring Hosp to Aircraft	Left at	HH MM
Base Hosp to Air Craft	Left at	HH MM	Flight time to Landing Rec. Hosp	Take off	HH MM
Flight Time to Referring Hosp	Take off	HH MM	Landing site to Rec. Hosp	Left at ____:____	Arrived at ____:____
Landing site to Referring Hosp	Left at	HH MM			

COMMENTS

Referring Hospital

Date: Patients Name:

PATIENT TRANSPORT OBSERVATIONS

Observations at commencement of preparation for transport and every 15- 30 mins during transport. Mandatory Observations: 1.At referring hospital unit 2.On departure from unit 3. On switch over to Ambulance/Aircraft gas & power supply 4. En route in Ambulance/Aircraft

Date																			
Date Observations: Time																			
Temperature: Axilla/core																			
210																			
200																			
190																			
180																			
Heart Rate. 170																			
160																			
Blood Pressure 150																			
Systolic ^ 140																			
Diastolic V 130																			
MAP X 120																			
110																			
100																			
90																			
80																			
70																			
60																			
50																			
40																			
30																			
20																			
ETCO2																			
SaO2																			
ECG Rhythm/Paced																			
MODE																			
PIP/PEEP																			
Respiratory rate																			
FiO2																			
Tidal Volumes																			
Infusions																			
Intake:																			
Output:																			
Neurological:																			
GCS /15																			
R Pupil																			
L Pupil																			

CHECKLIST

Airway: Secure ☐ CXR confirmed ☐

Ventilation: Ventilation established ☐ HME filter ☐ ABGS ☐

Oxygen Requirement: MV x FiO2 x (journey time in mins), x 2 (safety factor) = O2L needed
(____ __) x (__.__) x (_____) mins x 2 = _____ L
Sufficient O^2 for journey ☐

CVS:
- HR, BP optimised ☐ Tissue / organ perfusion ☐
- Bleeding controlled ☐ Blood volume restored ☐
- Hb adequate ☐ IV access; 2 routes ☐
- Arterial line ☐ CVC ☐

Neuro:
- Seizures controlled ☐ Metabolic cause excluded ☐
- Increased ICP managed ☐ Sedated / paralysed ☐

Trauma:
- Cervical spine protected ☐ Pneumothoraces drained ☐
- Thoraco/abdominal bleeding investigated / controlled ☐
- Intra abdominal injuries investigated/ ☐
- Long bone/pelvic fractures stabilised ☐
- Chest drains unclamped ☐

Metabolic: Blood Glucose >4mmol/L ☐ K+ < 6 mmol/L ☐

Monitoring: ECG ☐ BP ☐ SaO2 ☐ ETCO2 ☐ Temp ☐
- Patient ID band attached
- Stable on trolley ☐ Equipment secured ☐
- Infusions running, labelled ☐
- Adequately sedated / paralysed ☐
- Wrapped to prevent heat loss ☐
- Received appropriate handover ☐
- Adequate clothing ☐

Equipment:
- Fully equipped ambulance ☐
- Drugs/equipment as per checklist ☐
- Transport Bag ☐ Batteries checked (with spares) ☐

Organisation: Case notes ☐ Radiology ☐ Blood results ☐
- Bed secured ☐ Receiving consultant consulted ☐
- NOK informed ☐ NAS informed ☐
- Contact Receiving Unit before departure ☐
- Discharge summary + Letter ☐

Departure: Trolley secured ☐ Connected to ambulance power ☐
- Ventilator transferred to ambulance O2 ☐
- All equipment secured ☐ Staff seated, seat belts ☐

PRESCRIPTION

Date / Time	Solution	Drug	Prescriber	IMC NO	Sig 1	Sig 2

BLOOD PRODUCTS

Date	Time	Product	Batch Number	Expiry Date	Prescriber Signature	Given Signature

Retrieval Team

Comments

HANDOVER LOG

Team Members (name and initials please)

REFERRAL TEAM		RETRIEVAL TEAM		RECEIVING TEAM	
Dr	IMC	Dr	IMC	Dr	IMC
Signature	initials	Signature	initials	Signature	initials
Nurse	PIN	Nurse	PIN	Nurse	PIN
Signature	initials	Signature	initials	Signature	initials
Other					

NAS personnel Name/Signature