PATIENT ASSESSMENT

Diagnosis

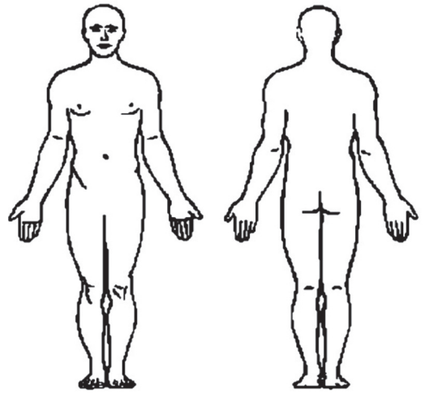
Diagnosis

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:

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.

Other

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

NEOC No.

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

Patients Name: DOB: Number:

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 secured/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 ☐
- Wrapped to prevent heat loss ☐
- Received appropriate handover ☐
- Adequate clothing (staff) ☐

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

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

In Ambulance:
- 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

Comments

ABG	PRE-DEPARTURE
PH	
PCO2	
PO2	
HCO3	
BE	
Lac	
Glu	
K	
Hgb	

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 Name/PIN