AEROMEDICAL EVACUATION PATIENT RECORD

PATIENT IDENTIFICATION

1. NAME *(Last, First, Middle Initial)*	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
		CIV	USMC	U P R	CWO-

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION *(1A-5F)*	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
60	Male / Female	240	O-	AMBULATORY / LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
	TMC KUWAIT NAVAL BASE	WALTER REED AMC	16a. MEDICAL / 16b. NON MED
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

18. BATTLE CASUALTY / DISEASE / NON-BATTLE INJURY

19. CLINICAL ISSUES *(Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)*

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARS/SINUS	j.			SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
		IODINE

20d. DIET: REG / 3GM NA / CARDIAC / DIABETIC ____ CALS

- RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4
- TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH
- PEDIATRIC: AGE ____ / OTHER *(Specify)* ____
- TPN: Change to D10 at ____ cc/hr for max of ____ days
- TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT

TRACTION	ORTHOPEDIC BRACES	
SUCTION	IV PUMP	CHEST TUBE/HEIMLICH
NG TUBE	TRACH	RESTRAINTS
STRYKER FRAME	MONITOR	OTHER *(Explain in 23)*
INCUBATOR	FOLEY	

O2: LITERS: 15 ROUTE: TRACH

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS	X-RAYS	FINANCIAL
INPATIENT RECORDS	OB RECORDS	OTHER *(Specify)*
NARRATIVE SUMMARY	DENTAL RECORDS	

20i. MEDICATIONS/TREATMENTS

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE	21d. RESP	21e. BP
	100.0	100	20	

22. BRIEF NARRATIVE

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES

Ready Date:
Birthdate:
Point of Contact:

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON