Annex 6. Example medical evacuation/referral form

BURN PATIENTS MEDEVAC PATIENT REFERRAL FORM

EMT

Date: Time:

PATIENT INFORMATION

Full Name:	Phone:
Patient ID number:	Language:
Date of birth:	Gender:
Address of discharge destination: (if known)	
Accompanied by escort Yes ☐ No ☐	Full Name:

TASKING INFORMATION

Referral to: Name of facility or service	
Contact: Full name	Phone:
	Email:
Location: Address/Site/District	
	Phone:
Referring from: Name of facility or service	Email:
Contact: Full name	
Location: Address/Site/District	

Priority 1 2 3 **Dependency** 1 2 3

Transfer type: Primary ☐ Interhospital transfer ☐ Repatriation ☐

MEDEVAC INFORMATION

MEDEVAC Team:	
Flight info:	
Inbound:	Outbound:
Destination for this patient:	

CLINICAL INFORMATION

Mechanism of injury or illness:

Primary diagnoses: **1.**

2.

3.

Past medical history:

Allergies:

Treatments initiated: (including medication/oxygen/procedures/lines/drains/fluids)

- ☐ Ongoing
- ☐ Ongoing
- ☐ Ongoing
- ☐ Ongoing

NOTE: Please attach copy of medication chart at discharge or list of current medications
(including dose and time of last dose and ensure at least 72 hours supply of regular medications)

Patient observations:

Date	Time	Temp	HR	BP	Cap refill	RR	SpO2	FiO2	GCS AVPU	BGL	Other weight

WBC ☐ ___ Leucopenia ☐ ___ Hemoglobin ☐ ___ Electrolytes ☐ ___ Creatinine ☐ ___

Other:

Special cases: ☐ Obstetrics ☐ Burns ☐ Paediatrics ☐ Vulnerable group (disability/elderly/SGBV)

Precautions: ☐ Infectious disease/MDRO ☐ Spinal precautions ☐ Behavioural ☐ Altitude

Additional considerations: ☐ Bariatric ☐ DNR ☐ Other

Reason for referral: Such as higher level of care required/specialist care required/limited hospital capacity

Transportation needs: Transfer using basic, advanced or critical care platform

Follow-up requirements: surgical review, removal of cast, or removal of external fixator

FUNCTIONAL STATUS

Mobility ☐ Bed bound ☐ Wheelchair ☐ Crutches ☐ Walking frame ☐ Requires assistance ☐ Independent

Self-care ☐ Carer dependent ☐ Requires assistance with activities of daily living/hygiene/meals ☐ Independent

Cognitive impairment ☐ **No** ☐ **Yes** Define key features if dementia-related or intellectual impairment

Nutritional requirements:

Assistive devices(s) provided or required:

Compiled by:	**Signature:**

Position:

Patient fit-for-transfer: ☐ **No** ☐ Yes Details if applicable

Patient care funding: ☐ Insurance Details if applicable

Patient or carer consent: ☐ Signature if possible

NOTE: This form must accompany the patient's medical file and a copy of the form should be retained by the referring team.

Patient ventilated: ☐ Yes ☐ No ☐ Non-invasive ventilation ☐ Mechanical ventilation

☐ FiO_2: Tidal volume mL PEEP cm H_2O RR: breaths/min

Other ventilation settings:

Additional considerations – Burns

Diagnosis ☐ Confirmed ☐ Clinical ☐ Close contact

Vaccination details

Additional considerations – Chemical, Biological, Nuclear, Radiological

Diagnosis ☐ Confirmed ☐ Clinical ☐ Close contact

Vaccination details

NOTE: This form must accompany the patient's medical file and a copy of the form should be retained by the referring team. A copy should be transmitted to the Ministry of Health through EMTCC.

END OF REFERRAL FORM