Transport Information: Date: | Air | Ground

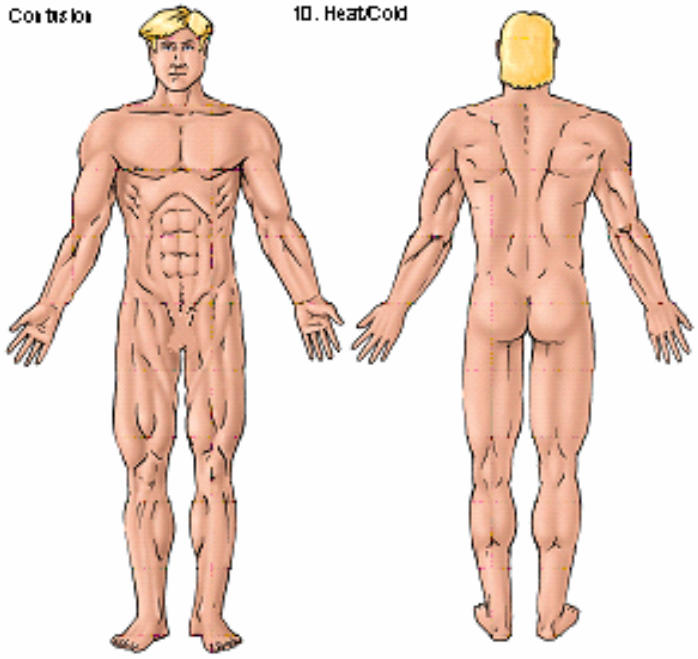
Enroute: _____ On Scene: _____
Depart Scene: _____ Destination: _____
Name of Destination: _____
Referring Physician: _____
Accepting Physician: _____

Vital Signs:

TIME: _____	TIME: _____	TIME: _____
B/P: _____	B/P: _____	B/P: _____
R: _____	R: _____	R: _____
P: _____	P: _____	P: _____
SPO2: _____	SPO2: _____	SPO2: _____
TEMP: _____	TEMP: _____	TEMP: _____

Injury/Wound Site By Number:

1. Abrasion
2. Amputation
3. Avulsion
4. Burn
5. Contusion
6. Crush
7. Edema
8. Fracture
9. GSW
10. Heat/Cold
11. Laceration
12. Puncture/Penetrating
13. Pain
14. Other see notes



Assessment: (Airway/Breathing/Circulation)

Airway/Breathing:	Lungs:	R	L
☐ Patent/Normal	Clear	☐	☐
☐ Obstructed	Decreased	☐	☐
☐ Symmetrical	Absent	☐	☐
☐ Asymmetrical	Wheezing	☐	☐
☐ Shallow	Rales/Rhonchi	☐	☐
☐ Labored			
☐ Trachea Midline Y: _____ N: _____			

Procedures:

☐ BVM
☐ ET Size #_____
☐ NT Size #_____
☐ J-Tube/OPA
☐ O_2 _____ L/min
☐ Crico Size #_____
☐ Mask

Circulation:

Cap Refill:
☐ < 3 sec
☐ 3-5 sec
☐ > 5 sec

Skin Color:
☐ Normal
☐ Pale/Ashen
☐ Cyanotic
☐ Flushed

Skin Temp:
☐ Normal
☐ Hot
☐ Warm
☐ Cool
☐ Cold

Skin Moisture:
☐ Normal
☐ Dry
☐ Moist/Clammy

Pulses: Location: _____
☐ Normal ☐ Weak ☐ Bounding ☐ Absent

Procedures:
☐ IV mL #_____ ☐ Peripheral ☐ Subclavian ☐ Femoral
☐ Interosseous Site: _____
☐ NS ☐ LR ☐ Dextrose
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Blood #_____
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Prehospital Treatment:
☐ C-Collar
☐ Spine Immobilization: Time On: _____
☐ Type: _____
☐ Splints
☐ Tourniquet: Time: _____ Location: _____
☐ CPR: Time Started: _____ Stopped: _____
☐ PASG: ☐ Legs ☐ Abd
☐ Chest Tube: ☐ R ☐ L ☐ Bilateral
☐ NG Tube
☐ OG Tube
☐ Other: _____

Mental Status:
TIME: _____
☐ A ☐ V
☐ P ☐ U
TIME: _____
☐ A ☐ V
☐ P ☐ U

GLASGOW COMA SCALE (Circle each value)

Eye Opening	Verbal Activity	Motor Activity
4 – Spontaneous	5 – Oriented	6 – Obeys Command
3 – To Command	4 – Confused	5 – Localized Pain
2 – To Pain	3 – Inappropriate	4 – Withdraws to Pain
1 – None	2 – Incomprehensible	3 – Flexion to Pain
	1 – None	2 – Extension to Pain
		1 – None

TOTAL SCORE: _____ TIME: _____

Medications Administered:

Narrative:

History:
Allergies:
Medication:
Pregnancy: ☐ Y ☐ N LMP:

Patient Identification:
Last, First MI:
SSN: Rank:
DOB:
Unit: Unit Phone:

MEDEVAC Provider Identification:
Last, First MI:
SSN: Rank:
Healthcare Provider Level:
MEDEVAC Unit: Unit Phone:
Signature:

DA Form XXXX (Test) Medical Evacuation Runsheet