PATIENT MOVEMENT RECORD

DATA PROTECTED BY PRIVACY ACT OF 1974 — PERMANENT MEDICAL RECORD — RESET FORM

(S) - Information needed to submit patient movement record

SECTION I — PATIENT IDENTIFICATION

(s) NAME (Last, First, Middle Initial)					(s) SSN	DATE OF BIRTH
(s) AGE	(s) SEX ☐ M ☐ F	(s) STATUS	(s) SERVICE	(s) GRADE	(s) UNIT OF RECORD AND PHONE NUMBER	CITE NUMBER

SECTION II — VALIDATION INFORMATION

(s) Medical Treatment Facility Origination and Phone Number		(s) Ready Date (Julian Date)	APPOINTMENT DATE N/A	NUMBER OF ATTENDANTS (s) MEDICAL	(s) NON-MED
(s) Medical Treatment Facility Destination and Phone Number		(s) CLASSIFICATION 1A-5F			
			AMBULATORY ☐	LITTER ☐	(s) PRECEDENCE
(s) Reason Regulated	Max # Stops	Max # CONS	Altitude Restriction	(s) CCATT Required ☐ yes ☐ no	Name, sex, weight, rank of attendants:	U P R ☐ ☐ ☐

SECTION III — OTHER INFORMATION

(s) Attending Physician name, Phone Number and e-mail	(s) Accepting Physician name, Phone Number and e-mail
(s) Origination Transportation 24 Hour Phone Number	(s) Destination Transportation 24 Hour Phone Number

(s) Insurance Company	Address	Phone #	Policy #	Relationship to policy holder

(s) Waivers (med equip, etc)

SECTION IV — CLINICAL INFORMATION

(s) Diagnosis

(s) Allergies

LABS (Date and time drawn in Zulu)

WBC	HGB	HCT	Other Labs

(s) WEIGHT: (S) Blood type:

☐ battle casualty ☐ disease ☐ non-battle injury

Vital Signs (Date and time taken in Zulu)

Date	Time (Zulu)	B/P	Pulse	Resp	Pain Level: /10	Last Pain Med:	O2/LPM:	Route:

Baseline 02 Sat If Applicable _____ Temp _____

CLINICAL ISSUES

Infection Control Precautions: **LMP:**

Date of last bowel movement:

High Risk for Skin Breakdown ☐ yes ☐ no

Initial appropriate boxes:

Yes	No		Yes	No	
☐	☐	Hearing Impaired	☐	☐	Hypertension
☐	☐	Communication Barriers	☐	☐	Dizziness
☐	☐	Vision Impaired	☐	☐	Voiding difficulty
☐	☐	Cardiac Hx	☐	☐	***Takes long-term meds**
☐	☐	Diabetes	☐	☐	***Will self-medicate**
☐	☐	Motion Sickness	☐	☐	Has adequate supply of meds
☐	☐	Ears/Sinus Problems	☐	☐	Knows how to take meds (verbalized understanding)
☐	☐	Respiratory difficulty			
☐	☐	***Medication listed on physician's orders**			

SPECIAL EQUIPMENT (Check all that apply)

☐	Suction	☐	Traction	☐	Orthopedic devices	OTHER:
☐	NG Tube	☐	Monitor	☐	Restraints	
☐	Foley	☐	Trach	☐	Chest Tubes	
☐	Incubator	☐	IV Pumps	☐	IV Location:	

☐ Cast /Location: _____ Bivalved: ☐ yes ☐ no

☐ Ventilator Ventilator Settings:

DIET INFORMATION (Check all that apply)

☐ NPO ☐ Soft ☐ Full Liq ☐ Cl Liq ☐ Reg

☐ Renal _____Gm Protein _____Gm Na _____Meq K _____Mag Sulfate

☐ Tube Feeding _____Type _____cc/hr _____Discontinue for Flight

☐ Cardiac ☐ Diabetic _____ cal ☐ Infant formula: Pediatric Age:

☐ TPN:

☐ Other(specify):

SECTION V — PERTINENT CLINICAL HISTORY (Transfer Summary)

Physician's Signature	Date/Time
Signature of Clearing Flight Surgeon	Date/Time

AF IMT 3899, 20060819, V1

"Per AFI 48-307V3" The attending provider will sign the AF Form 3899; consultation with the TPMRCW TVFS has been completed- the patient is stable and cleared for Flight."

PATIENT MOVEMENT RECORD (continuation)

DATA PROTECTED BY PRIVACY ACT OF 1974 **PERMANENT MEDICAL RECORD**

PATIENT MOVEMENT PHYSICIAN ORDERS(for continued care in the AE system and at enroute stops)

SECTION I. PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. GRADE	3. SSN#
4. ALLERGIES	5. ORIGINATING MTF	6. DESTINATION MTF

SECTION II. MEDICATION ORDERS (Drugs and IVs)	SECTION III. OTHER ORDERS (Procedures, Treatment, V/S Frequency, ETC)
☐ yes ☐ no patient will self-medicate with the following medications:	