

PATIENT MOVEMENT RECORD

DATA PROTECTED BY PRIVACY ACT OF 1974

PERMANENT MEDICAL RECORD

(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		(s) STATUS	(s) SERVICE	(s) GRADE	(s) UNIT OF RECORD AND PHONE NUMBER	CITE NUMBER		
	M	F							

SECTION II VALIDATION INFORMATION

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

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:		Vital Signs (Date and time taken in Zulu)								
battle casualty		disease		Date	Time (Zulu)	B/P	Pulse	Resp	Pain Level: /10	Last Pain Med:	O ₂ /LPM:	Route:
non-battle injury												

CLINICAL ISSUES			Baseline 02 Sat If Applicable _____						Temp _____						
Infection Control Precautions:			LMP:		SPECIAL EQUIPMENT (Check all that apply)						OTHER:				
Date of last bowel movement:					Suction	Traction	Orthopedic devices								
High Risk for Skin Breakdown			yes	no	NG Tube	Monitor	Restrains								
Foley					Foley	Trach	Chest Tubes								
Initial appropriate boxes:					Incubator	IV Pumps	IV	Location:							
Yes	No		Yes	No	Cast Location: _____							Bivalved:	yes	no	
		Hearing Impaired			Ventilator Ventilator Settings: _____										
		Communication Barriers			DIET INFORMATION (Check all that apply)										
		Vision Impaired			NPO	Soft	Full Lig	CI Liq	Reg						
		Cardiac Hx			Renal	Gm Protein	Gm Na	Meq K	Mag Sulfate						
		Diabetes			Tube Feeding	Type	cc/hr	Discontinue for Flight							
		Motion Sickness			Cardiac	Diabetic	cal	Infant formula:		Pediatric Age:					
		Ears/Sinus Problems			TPN:										
		Respiratory difficulty			Other(specify): _____										
		*Medication listed on physician's orders													

SECTION V PERTINENT CLINICAL HISTORY (Transfer Summary)

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

