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	(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 # 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:
battle casualty	disease
non-battle injury	

Vital Signs (Date and time taken in Zulu)

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

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

"Per DAFI 48-107V3, The attending provider will sign the AF Form 3899; consultation with the TPMRCW TVFS has been completed-the patient condition, 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:	

Additional Attendant Information (attendant #1 listed on front)

	2	3	4	5
Name				
Rank				
DOB				
SSN / DOD				
Height/ Weight				
Gender				
Role				

Physician's Signature:

"Per DAFI 48-107V3, The attending provider will sign the AF Form 3899; consultation with the TPMRCW TVFS has been completed-the patient condition, is stable and cleared for Flight."