Patient assessment and transport

Patient presentation - adult and child

General principles[1]

- The first priority is to assess whether the patient is seriously ill and needs immediate management, or is less acutely sick giving time to get a full history
- Always ask open questions
- In children, pay particular attention to history from parent/carer where available

Rapid assessment

- **D**anger
- **R**esponse
- **S**end for help if unresponsive
- **A**irway - compromised
- **B**reathing - not breathing, significant respiratory distress
- **C**irculation - pulse absent, slow, rapid or profuse bleeding
- **D**isability - **A**lert, **V**oice, **P**ain, **U**nresponsive
- Rapid history, allergies
- Vital signs - RR, SpO_2, HR, BP, T - use appropriate Q-ADDS/CEWT/MEWT (Qld) or local EWARS
- Consider BGL

Any **COVID-19** signs/symptoms

- For the latest information on infection control, testing and management refer to **local policy, or** http://disease-control.health.qld.gov.au/condition/837/2019-ncov **(Qld)** or your state/territory guidelines
- Also see *Australian guidelines for the clinical care of people with COVID-19* https://covid19evidence.net.au/#living-guidelines

Is patient immediately at risk

Yes

Perform immediate stabilising or life saving measures. See
Basic life support, p. 46
Advanced life support, p. 48
Or other topic relevant to urgent presentation

Consult MO/NP as soon as circumstances allow

No

Note: if trauma related eg fall/hit by an object/motor vehicle accident, promptly assess against Criteria for early notification of trauma for interfacility transfer (inside front cover)
If meets criteria contact ✆ RSQ 1300 799 127
or RFDS 1300 697 337
If outside Qld, refer to local early notification process

Get history and do physical examination as relevant. See
History and physical examination - adult, p. 17
or History and physical examination - child, p. 480

Form a clinical impression

Select appropriate topic to guide further assessment and management

Adult presentation

History and physical examination - adult

Recommend

- If child, see History and physical examination - child, p. 480
- Ensure a culturally safe environment. As appropriate, be guided by local health workers
- Document your findings clearly, concisely and in logical sequence - use this section to assist
- Offer opportunistic health promotion, screening and brief intervention for lifestyle modification(s) during visit as appropriate.[1,2] For screening tools and checks, see the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm

Background

- The history is the most powerful tool for identifying the likely diagnosis in most cases[1]
- Types of history:[2]
  - **complete** - comprehensive history of the patient's past and present health status. Usually done at initial visit in a non-emergency situation
  - **focused/problem centred** - shorter and specific to the patient's current presenting concern
  - **follow up** - evaluation of problem from preceding visit
  - **emergency** - urgent, rapid collection of crucial information compiled concurrently with life-threatening measures. Take a comprehensive history once patient is stabilised

Related topics

History and physical examination - child, p. 480
Mental health emergency, p. 336
STI/BBV assessment, p. 445
Traumatic injuries, p. 134

Vital signs - adult approximate normal values[1,2]	
Temperature (**T**) (oral, tympanic)[3]	35.5–37.5
Heart rate (**HR**)	60–100 beats/minute
Respiration rate (**RR**)	12–20 breaths/minute
Blood pressure (**BP**)	Systolic < 130, diastolic < 85
O_2 saturation (**SpO_2**)[4]	≥ 94%
Conscious level (**A**lert, **V**oice, **P**ain, **U**nresponsive)	Alert
Capillary refill time (**CRT**)[3]	≤ 2 seconds
Blood glucose level (**BGL**)[5]	4.0–7.8

Step 1: Obtain history of the presenting concern/problem[1,6]

- Taking the history is the first step in making a diagnosis
- Use the history to guide the physical examination/further investigations
- An accurately acquired history will usually suggest the diagnosis. The physical examination and investigations should be used to confirm your diagnostic impression

History of the presenting concern/problem[1,6]	
Presenting concern/ problem	• Ask what the problem is • Use open ended questioning
For each symptom ask about (as relevant) Use SOCRATES mnemonic	• Ask about length of illness and details of each symptom(s) • **Site** - where is the symptom - localised or diffuse • **Onset**: – gradual, rapid or sudden – continuous or intermittent – what were they doing when it started • **Character** eg if pain: – sharp, dull, burning, stabbing, cramp like, crushing, tingling • **Radiation** - (if localised) does it travel elsewhere • **Alleviating factors** - does anything make it better eg sitting up, medicine(s), analgesia • **Timing**: – when did it first begin, duration – have they had it before – any increase in severity • **Exacerbating factors** - does anything make it worse eg movement, exercise • **Severity**: – does it interfere with sleep or normal activities – if pain - mild, moderate or severe OR severity on scale of 1–10
Associated/other symptoms	• eg nausea, vomiting, photophobia, headache, appetite, urine, bowels, energy • Ask specifically about **fever, pain, shortness of breath (SOB), diarrhoea, weight loss**
Treatment ± medicine(s) taken during this illness	• What, how much, when, how often, effectiveness
• Ask if there are any other concerns • Consider possible differential diagnosis • Subsequently use closed ended questions to confirm or refute your differential diagnoses	

Step 2: Ask about past history[1,6]

- Review and update past history in medical record each visit. As appropriate, check *My Health Record* https://www.myhealthrecord.gov.au
- Consider past history that may assist with differential diagnosis this visit
- Always ask about allergies and medicines

Past history[1,6]	
Past medical and surgical history	• Significant illnesses in the past • Ask about - diabetes, hypertension, angina and heart attacks, epilepsy, asthma, mood, mental health problems • Previous hospital admissions, operations or injuries - where, when, why • Is patient immunocompromised eg:[7] – diabetes, chronic kidney disease or hepatitis, alcoholism, malnutrition, liver failure, cancer, no spleen, lupus, multiple sclerosis, rheumatoid arthritis, HIV, Down syndrome, corticosteroids, chemotherapy
Family history	• Health problems in siblings and parents eg diabetes, hypertension, heart disease, stroke, epilepsy, asthma, cancer, mental health
Social history	• Usual GP + contact details if available • Job, living conditions, who else lives at home and what responsibilities do they have in the family. Means of communication for contact/follow up eg phone • Who their partner is or if they are in a relationship • Gender identification and pronouns patient identifies with eg her/him • Smoking/ever smoked - how many a day, ever tried giving up; e-cigarette use • Alcohol - what, how much + often. Express in standard drinks per day or week • Recreational drugs • Recent overseas travel (if infectious disease possible) - where/when • Diet, exercise
Medicines Also see Best possible medication history, p. 560	• Regular and prn medicines - prescribed/over-the-counter, complementary, alternative, bush medicines, vitamins, oral/other contraceptive (females): – generic name, dose, route, frequency – explore adherence and any barriers to taking medicines as prescribed – recently changed/course completed • If patient has medicines with them, check against medical record
Allergies **Adverse medication reactions**	• Allergies/reactions + type of reaction (anaphylaxis, skin reaction, other) to: – medicines – other eg honey bee stings, sticking plaster, food – is adrenaline (epinephrine) autoinjector used eg EpiPen® • Check medical record + document allergies/adverse reactions[9] • Check medic alert jewellery/accessories eg key ring, USB, shoe tag, anklet, watch, tattoo[8]
Immunisations	• Check if up-to-date, including COVID-19 vaccination status • Offer opportunistic Immunisations, p. 554 as appropriate
Opportunistic health checks (offer or refer as appropriate)	• Check if due for routine health checks eg STI/BBV tests, p. 448, Cervical Screening Test, mammogram, bowel screening • See the *Chronic conditions manual* https://www.health.qld.gov.au/rrcsu/clinical-manuals/chronic-conditions-manual-ccm for **adult health checks**

Step 3: Do physical examination[1,6]

- Most information will be gained from history taking. Use this information to guide examination
- **In an adult who is not sick**:
  - examine the relevant system first
  - proceed to further examination if required. Be guided by your findings
- **In a sick adult**:
  - examine the relevant system first followed by ALL other systems
- Use a systematic approach to physical examination

Physical examination - adult[1,6]	
Vital signs	• RR, HR, BP, T, SpO_2 • Conscious state - GCS/AVPU, p. 562 • If indicated: – BGL – capillary refill time (≤ 2 seconds) **Document on appropriate Q-ADDS (Qld) or local EWARS** If pregnant/postnatal, use appropriate Q-MEWT rural and remote tool **Calculate score. Act on score if indicated**
General appearance	• Do they look sick/not sick (well) • Observe: – posture, mobility – any ↑ work of breathing (WOB), breathlessness – conjunctiva and nail beds - are they pale – lips, tongue and fingers - are they blue – general skin colour - pale/jaundiced – agitation, distressed – body/breath odours – sweating – are they well nourished • Weight ± height, BMI and waist measurement
Hydration	• Eyes - normal or sunken • Mouth and tongue - wet or dry • Skin turgor - normal or reduced. Pinch skin - normal skin returns immediately on release (normal can be reduced in elderly) • Dry axillae • Recent weight loss/gain

Physical examination - adult[1,6] (continued)	
Skin	• Check the whole body in a sick patient: – consider removing clothing to underwear • Look for: – rashes - vesicular, macular, papular, petechiae, purpura – signs of infection - redness, swelling, tenderness – bruising, unexplained or unusual marks – general pigmentation - areas where skin is lighter or darker • Any skin lesions or sores: – colour, shape, size, location, distribution on body – non-blanching – vesicles present – exudate eg clear, pus, bloody – any family members/close contacts with similar lesions • Palpate/feel skin: – temperature, dryness/moisture, clamminess – any tender/enlarged lymph nodes in the neck, axillae or groin
Cardiovascular system	• Also see Chest pain assessment, p. 103 • Any: – pain/pressure in neck, chest, arms – SOB on exertion – evidence of oedema, particularly feet, hands, face or sacrum • Check skin: – colour - pink, white, grey, mottling. Compare trunk with limbs – temperature - hot, warm, cool or cold. Compare trunk with limbs • Central perfusion - blanch skin over the sternum with your thumb for 5 seconds. Time how long it takes the colour to return • Peripheral perfusion - blanch the skin on a finger or toe for 5 seconds. Time how long it takes for the colour to return • Look for distended neck veins • If trained in auscultation listen to heart sounds
Respiratory system	• Most information is gained from simple observation • Inspect anterior/posterior chest - equal chest expansion, abnormal chest movement, ↑ WOB, use of accessory muscles, tracheal tug • Can they talk in full sentences, single words or unable to talk at all • Measure RR over 1 minute - note rhythm, depth and effort of breathing • Listen for extra noises - cough (loose, dry, muffled ± sputum), wheeze, stridor, hoarseness • Auscultate for air entry into both lung fields: – equal, adequate – any wheeze or crackles - on inspiration or expiration • Percuss lung fields - dull, resonant, hyper-resonant • Can they lie flat without breathlessness

Physical examination - adult[1,6] (continued)	
Gastrointestinal/ reproductive system Consider cultural safety/sensitivity	• Inspect abdomen for scars, distension, hernias, bruising, masses • Auscultate bowel sounds in all 4 quadrants - present or absent • Palpate abdomen: – soft or firm – obvious masses – tender to touch. Identify abdominal quadrant and exact area – guarding or rigidity even when the patient is relaxed – rebound tenderness - press down and take your hand away very quickly, is pain greater when you do this • Change of bowel habits • Ask women: – date of last normal menstrual period – abnormal vaginal bleeding or discharge • Do pregnancy test in females of reproductive age with abdominal pain • In men: – if relevant check the testes - any redness, swelling or tenderness – ask about penile discharge • See abdominal examination, p. 197 for detailed assessment
Nervous system	• Assess conscious state. See GCS/AVPU, p. 562 • Any dizziness, fainting, blackouts, problems with speech, vision, weakness in arm/leg, altered sensation, neck stiffness • Assess orientation to time, place and person: – ask - name, date of birth, location, time, date, year • Check: – pupils - size, symmetry, reaction to light – for asymmetry of tone and power - compare each side of the face and limbs – if indicated, test touch and pain sensation - using cotton wool and the sharp end of the percussion hammer – test finger nose coordination and if possible observe the patient walking
Musculoskeletal system	• Ask if any painful or stiff joints or muscular pain • Observe gait • Inspect joints for redness, swelling or lacerations over or near a joint
Eyes	• As indicated, test the Visual acuity, p. 278 of each eye • Inspect: – eyes and surrounding structures - any redness, discharge or swelling – pupils - equal in size, regular in shape, reaction to light – eye movements • See Eye assessment, p. 276 for detailed assessment

Physical examination - adult[1,6] (continued)	
Ears, nose and throat	**Ears** • Inspect - pinna - any redness, swelling, nodules • Any obvious swelling or redness of the ear canal. If there is, looking with an otoscope will be painful • Using otoscope, inspect: – canal - any redness, swelling, discharge, foreign bodies (insects/objects) – eardrum - normal, redness, dullness, bulging/retraction, fluid, bubbles, perforations or discharge • Check behind the ear (mastoid) for redness, swelling, pain • See Ear assessment, p. 519 for detailed assessment **Nose** • Feel for facial swelling (sinuses), pain • Any discharge or obvious foreign body **Throat** • Inspect - lips, buccal mucosa, gums, palate, tongue, throat for: – colour changes, swelling, bleeding, pus, fissures – tonsils - redness, enlargement, pus – teeth and gums
Urine	• Check urine in all sick patients and if: – abdominal pain (+ do pregnancy test if female of reproductive age) – urinary symptoms – diabetes • Do urinalysis • Note colour - normal, dark or blood stained, cloudy • Does it smell normal

Step 4: Consider differential diagnosis

- If unsure, collaborate with MO/NP

Step 5: Select *Health Management Protocol* (HMP) or *Clinical Care Guideline* (CCG)

- To guide further assessment and management
- Document the page number of the HMP/CCG referred to in the medical record

Step 6: Order/collect pathology if indicated

- RIPRN:[10]
  - may order pathology as per the PCCM
  - name and signature of the MO, NP or RIPRN must be on pathology form or follow local protocol for electronic ordering
  - if RIPRN orders pathology, they are responsible for following up the result
  - consult MO/NP if results are abnormal/concerned about results
- Other clinical staff may be able to request pathology if there is a local agreement in place between the director of the clinical unit and Pathology Qld or local health service
- Write or record on electronic request 'copy of report to…' RFDS/other collaborative health provider on the pathology form as appropriate

- Point of care testing (PoCT) is available in some facilities eg i-STAT
- See Pathology Qld for:
  - pathology test list
  - rural and remote pathology request forms
  - see https://www.health.qld.gov.au/healthsupport/businesses/pathology-queensland/healthcare
- If outside Qld refer to local pathology services

Step 7: Collaborate with MO/NP as needed

- Always consult MO/NP if you are unsure
- Have Q-ADDS/CEWT/MEWT score completed
- Use ISOBAR, p. 25 to guide your communication
- Check your local facility guidelines to find out who to contact - during and after hours:
  - **if in doubt call RSQ**

Queensland contacts may include		
Local/on-site MO/NP	• **Check contact details/on call roster at your workplace**	
Retrieval Services Queensland (RSQ)	• 24 hour telehealth, coordination and emergency medical advice • For critically unwell, high acuity patients eg if local doctor not available, or if RSQ is your first point of contact	**1300 799 127** Keep your video conferencing equipment switched on at all times. RSQ will make a video conference call. No need to use remote control https://qheps.health.qld.gov.au/rsq
Royal Flying Doctor Service (RFDS) (Queensland Section)	• 24 hour routine and emergency medical advice, support and coordination for primary health care facilities where RFDS provide GP and aeromedical retrieval services	**1300 697 337** (1300MYRFDS)
Telehealth Emergency Management Support Unit (TEMSU)	• For lower acuity, non-critical clinical support and advice via video conference • 24 hour, 7 day a week nursing support to rural and remote nursing staff in Queensland Health facilities • Medical and subspecialty support may be available depending on locally agreed pathways	**1800 11 44 14** https://qheps.health.qld.gov.au/temsu

Clinical consultation

Consulting with MO/NP/retrieval co-ordinator[1]

- Be clear and methodical
- Write your findings down first, time permitting
- Advise early if you think the patient may need evacuation
- Say what you think is wrong. Your assessment is important

I	**Identify** yourself **AND** identify name and spelling of receiving MO/NP • I am ... (your name and role) • I am calling from ... (location)
S	**Situation** and **status** - why are you calling • I have a patient ... (name, age and gender) • I think the patient is/has ... (clinical impression/suspected diagnosis/unsure but worried) • Who is ... (stable/unstable/deteriorating/improving)
O	**Observations** • Most recent observations • The Q-ADDS/MEWT/CEWT score is ... (or if outside Qld, local Early Warning and Response System score) • General appearance • Weight
B	**Background** • History of presenting problem, relevant past history • Evaluation - physical examination, findings, investigation findings • Allergies • Current medicines • I have ...(taken the following actions eg given O_2, inserted IVC, started IV sodium chloride 0.9%)
A	**Agree to a plan** • I am wanting ... (advice, orders, evacuation) • Level of urgency is ... • Agree on plan of action with MO/NP/retrieval co-ordinator
R	**Recommendations** and **read back** • Confirm shared understanding of what needs to happen - who is doing what and when • Read back critical information • Identify parameters for review or escalation • Identify any risks

Patient retrieval/evacuation

1. Who to contact

- Usually the MO/NP, or Director of Nursing (DON) if possible, will arrange evacuation if required
- Be guided by local facility policy as to which retrieval service to contact:
  - RSQ 1300 799 127
  - RFDS 1300 697 337 if the community is normally serviced by the RFDS (for advice and evacuation). RFDS will advise RSQ of evacuation requirement
- **If you think a patient may need evacuation/retrieval, contact the relevant retrieval service EARLY**:
  - even if transport requirement not confirmed
  - this helps allocate resources
- Notify change of clinical condition of patient if worsening or improving:
  - flight priority can always be reassessed

Retrieval Services Queensland (RSQ) 1300 799 127

- Retrieval Services Queensland:
  - provides clinical coordination for aeromedical transfer for patients from parts of Northern NSW to the Torres Strait
  - utilises multiple government and non-government organisations to achieve aeromedical coverage of Queensland - eg RFDS Qld, QAS, QGAir Helicopter Rescue, Life Flight Retrieval Medicine
  - provide specialist medical and nursing coordinators in adult, paediatric, neonatal and high-risk obstetrics
  - returns patients to referring centres where aeromedical transfer is required
- **Emergency retrieval and transport criteria of patient:**
  - meets early notification of trauma criteria. See Criteria for early notification of trauma for interfacility transfer (inside front cover)
  - requires aeromedical evacuation
  - Q-ADDS/CEWT/MEWT ≥ 6 or E
  - › 2 hours/200 km by road to receiving hospital
  - requires medical escort
  - all neonate/high-risk obstetric, critically ill/injured adult and paediatric patients
- For further information https://qheps.health.qld.gov.au/rts

Royal Flying Doctor Service (Queensland Section) (RFDS) 1300 697 337

- The Royal Flying Doctor Service in Queensland provides access to primary health care and aeromedical services across the state
- RFDS emergency retrieval service operates 24 hours a day, seven days a week
- In addition to aeromedical retrievals of the critically ill or injured, the RFDS also delivers a broad range of essential primary and preventative healthcare services, including telehealth, mental health, oral health and health promotion

2. Retrieval preparation

Retrieval preparation	
Documentation	• Complete retrieval/**RFDS Aeromedical retrieval checklist** • Ensure documentation goes with patient including: – pre-hospital documentation – referral letter – copy of nursing/medical records – pathology results – recent set of clinical observations – up-to-date ECG (especially patient with chest pain) – x-rays – if digital radiology available, electronically transfer x-ray(s) to receiving facility
Handover location	• Handover location will be determined during the retrieval coordination process • If patient stabilised and prepared, handover at airport/airstrip may occur • Critical and unstable patients will be reviewed at the referring facility by the retrieval team prior to transport
Patient escort and baggage Space and weight restrictions apply	• If room, an escort may be carried at the discretion of the pilot: – name, weight of escort required • Maximum baggage allowance is 1 small bag with a weight of 5 kg • Medical aids/additional baggage at the pilot's discretion • Confirm no cigarette lighters in luggage

General preparation		
Consideration	**Requirements**	**Rationale**
Allergies/ identification	• Apply ID bands if available	• Rapid correct identification
Weight, height + widest point	• If › 120 kg, measure width at widest point eg shoulder or hips as per **RSQ Bariatric sizing chart** (Qld) https://qheps.health.qld.gov.au/rsq/forms	• Assists planning transport
Analgesia	• Give analgesia as clinically indicated prior to transfer • See Acute pain, p. 32	• Movement of the patient may exacerbate pain
Antiemetic	• Parenteral antiemetic essential if: – head, spinal, or penetrating eye injury • Consider for history of motion sickness or general nausea • Give 30 minutes prior to transfer • See Nausea and vomiting, p. 40	• Vomiting may exacerbate certain clinical conditions by raising ICP and intraocular pressure (IOP) • Puts airway at risk • Motion sickness common in aeromedical environment
Intravenous cannula (IVC)	• Ensure most patients have at least 1 IVC • IVC x 2 in critically ill/disturbed patients	• IV access may be difficult during flight due to space restrictions and turbulence
Urinary catheter (IDC)	• Get patients to empty their bladder prior to transfer • Insert IDC if is/may be incontinent	• No toilet facilities on aircraft • Use of bedpans is avoided due to limitations of space and waste disposal

General preparation (continued)		
Consideration	**Requirements**	**Rationale**
Parenteral medicine infusion	• Prior to transfer prepare infusions using compatible equipment, if possible, when using RFDS or other retrieval services	• Time is saved if infusions are prepared prior to RFDS arrival
Nasogastric tube (NGT) or orogastric tube (OGT)	• Ensure NGT/OGT inserted in: – all ventilated patients – patients with bowel obstruction	• Allow for drainage of stomach contents and reduce risk of vomiting and aspiration
Nicotine patch	• Offer to patients who are smokers	• Patient comfort
Specific medical conditions		
Consideration	**Requirements**	**Rationale**
Mental illness/disturbed behaviour	• Reliable IV access. If possible IVC x 2 • Complete RFDS risk assessment *Transfer of disturbed patients including patient with a mental illness* • Sedation and physical restraint may be required. Seek medical advice	• For aviation safety, special requirements apply to transportation of patients showing signs of disturbed behaviour, or regarded as being a danger to themselves or others
Infectious conditions	• Always advise retrieval coordinator of infectious conditions • COVID-19 risk assessment	• Limited ability to isolate patients in aircraft
Spinal injury	• Transport on vacuum mattress • Insert IDC • Insert NGT if have altered LOC	• To maintain stabilisation
Bowel obstruction	• Insert NGT - leave on free drainage or attach anti-reflux valve (do not spigot) • Give parenteral antiemetic and adequate analgesia prior to transfer	• Trapped gas will expand in volume at altitude and cause pain. NGT will allow gas to escape and reduce vomiting
Pneumothorax	• Ensure intercostal catheter in place • Connect to Heimlich valve or Portex® ambulatory chest drain system • Suspected pneumothorax should be excluded, if possible, by appropriate imaging	• Trapped gas in the pleural cavity will expand at altitude and may result in respiratory compromise • Underwater seal drains are avoided due to the risk of retrograde flow during transfer
Penetrating eye injury	• Give antiemetic to all patients with proven or suspected eye injury • Patients may be transported at reduced cabin altitude	• Trapped gas in the globe will expand at altitude and potentially worsen the injury • Vomiting may also exacerbate injury by raising intraocular pressure

Royal Flying Doctor Service

RFDS Aeromedical Retrieval Checklist

Date and time of request for retrieval/transport		ETA (will be confirmed in flight)	

PATIENT TRANSPORT DETAILS

Patient Name:		Patient Weight (kg): Complete Bariatric sizing chart if > 120kg	❑ Valuables - Specify:
Date of Birth:		Sex: M ❑ F ❑	❑ Small bag <5kg *Any other luggage must be approved by RFDS flight crew*
Address:			Escort *(must be approved by RFDS flight crew)* / Approval ❑ Weight (kg)
			Escort Name / Escort Relationship to Patient
Diagnosis			
Infectious Condition (e.g. .MRSA)	Yes ❑ No ❑ Specify:		Next of Kin / Contact Number
Mobility	❑ Able to manage stairs	❑ Requires Stretcher	

PLEASE NOTE:

■ Please advise RFDS MO or Clinical Coordinator immediately if clinical status deteriorates

■ Any patient with a fear of flying; who is claustrophobic; who is confused, agitated or aggressive must be discussed in full with the RFDS MO or RSQ Clinical Coordinator.

REFERRAL DETAILS

Referring facility		Referring Clinician	
Receiving facility		Receiving MO	

CLINICAL INFORMATION (✓ where applicable)

Infusion concentrations and rates must be documented on a fluid order sheet and a copy sent with the patient.

	Size	Site	Date Inserted	Infusion(s)
IV Cannula (1)				
IV Cannula (2) (see **General Preparation** section)				
❑ Toilet prior to flight	❑ Urinary Catheter	❑ ICC	❑ Chest drainage bag	❑ Fracture Immobilisation
❑ Gastric Tube (Free Drainage for Flight)		❑ Other (Specify)	❑	

Medicines given prior to transfer must be documented on a medication sheet and a copy sent with the patient
Ensure adequate analgesia and antiemetic is given if necessary

Medication given prior to flight	Dose and route given	Time given
Analgesia:		
Antiemetic:		
Sedative:		
Other:		

DOCUMENTATION

All patients must be accompanied by the appropriate documentation

Copies/originals of all the following *must* accompany

LETTER:
❒ Medical
❒ Surgical

OBSERVATION FORMS:
❒ Vital Signs
❒ Neurological Observations
❒ Blood Glucose Levels

❒ Current Medication Sheet
❒ Fluid Orders
❒ Fluid Balance Chart
❒ ECGs
❒ Pathology Results
❒ ARP/AHD

Other documentation that *may* be relevant during transfer

❒ Inpatient Notes
❒ Emergency Dept. Flow Sheet
❒ QAS Report Form
❒ Theatre Notes
❒ Immunisation Status
❒ PTSS Form

❒ QAS MATT Form
❒ Request for Assessment

PATHOLOGY SPECIMENS
❒ IATA Packing Instruction 650

HANDOVER

Handover location and road transport details will be determined by RFDS/RSQ during coordination of the retrieval

❒ Hospital Handover *OR* ❒ Airport Handover	❒ RFDS to arrange ambulance *OR* ❒ Hospital to arrange ambulance	Discuss any questions with the RFDS Medical Officer or RSQ Clinical Coordinator, and/or refer to Primary Clinical Care Manual.
Additional Comments:		Name: / Signature:

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