DEPARTMENT OF HEALTH AND FAMILIES

REMOTE HEALTH MEDICAL EVACUATION FORM

PRINCIPAL NAME	OTHER NAMES	HRN	
HEALTH CENTRE Ph:_____ Fax:_____	CLIENT'S USUAL ADDRESS / COMMUNITY	DOB ___ / ___ / ___	Male ☐ Female ☐

Next of Kin:	Relationship:	Address / Community:	Phone Contact:
Escort:	Relationship:	Address whilst in town:	Contact in town:

Name/s (and designation) of clinical staff attending:

STORY / PRESENTING PROBLEM

Possible Diagnosis / Primary reason for evacuation:

RELEVANT MEDICAL & SURGICAL HISTORY

or refer to PCIS summary sheet - attached ☐

ALLERGIES / ALERTS:

CLINICAL EXAMINATION

Name: **DMO consulted:**	**Date:**	**Time:**

DHF utilises personal information in accordance with the ***Information Act*** and the ***DHF Privacy Policy***

NAME: _____ **HRN:** _____

OBSERVATIONS

Date / Time	Pulse	BP	Resp	Sats	GCS	Temp	BGL			Notes
		/								
		/								
		/								
		/								
		/								
		/								
		/								
		/								
		/								
		/								
		/								
		/								

Hb:		Wgt:	kg	U/A		β-hCG :	☐ Pos ☐ Neg

Date / Time		TREATMENT / DRUGS / FLUIDS	Dose / Vol.	Route	Prescribed by: *(Doctor name)*	Given: *(initial)*

IV Cannula 1:	Size: _____ gauge Site: _____	IV Cannula 2:	Size: _____ gauge Site: _____	Other:	

PRE - EVACUATION CHECKLIST *(tick if done ☑)*

Pre-Evac Checklist

- ☐ Client agrees/consents to evac
- ☐ Need for escort (D/W DMO)
- ☐ Escort arranged (if required)
- ☐ Hydration adequately managed
- ☐ Analgesia - adequate pain relief ?
- ☐ Anti-emetic pre-flight ?
- ☐ Consider sedation / antipsychotic
- ☐ Psychiatric client - risks managed

Mandatory documents to copy & attach

- ☐ **Medication script (current)**
- ☐ **PCIS Summary**

OR

- ☐ **Medical Summary form**
- ☐ **Immunisation record**

** ***Ensure a copy of this form remains in medical record***

Prompt for additional documents

- ☐ Progress notes
- ☐ Growth Records
- ☐ Pathology results
- ☐ Antenatal summary
- ☐ ECG (most recent)
- ☐ Chronic Disease Care Plan
- ☐ Fluid balance chart
- ☐ Other relevant observation chart

HAND OVER					
	From:	Name of Clinician	Signed	**Date:**	
	To:			**Time:**	

DHF utilises personal information in accordance with the ***Information Act*** and the ***DHF Privacy Policy***