Patient Name: ______________________

AERO-MEDICAL EVACUATION

REQUIREMENTS FOR PATIENT MOVEMENT REQUEST

1. AF 3899 - Signed (front and back)
2. **ALL SPACES MUST BE COMPLETED!**
3. Incomplete spaces and/or missing information will result in delay of patient movement.

Administrative Information

***Origination Facility**

- Physician Name & Direct Line for 3899:____
- POC Name and Phone/Pager Number: ____
- Clinic/Ward & Phone Number : ____
- Social Worker Name & Phone Number:____

***Destination Facility**

- Facility Name & Number: ____
- Accepting Physician Name & Direct Number: ____
- Acceptance Policy (ex. 24/7, M-F 0700-1500): ____
- Point of Contact Name & Phone Number:____
- MTF Transportation or Medevac/Aerovac Number: ____

***Civilian/VAMC Facilities:**

- Tricare Authorization Number for Ground Transport: ____
- Tricare Authorization Number for In-Patient Care: ____

Medical Attendant Information (If Required) ***All MA must have TAD orders for travel.***

Name/Rank/Position: ____

SSN: __________________________Date of Birth: _________________________ Weight: ________________

Address____

City ___________________________ State ____________ Zip __________Telephone: ________________________

Non-Medical Attendant Information (If Required)

Name: ____Relationship: ___________

SSN: ___________________ Date of Birth: ___________________________Weight: ________________

Address____

City ___________________________ State ____________ Zip __________Telephone: ________________________

Addtional space for addentants can be entered on pages 5 and 6, if requried.

Patient Home Record (REQUIRED)

Address____

City ___________________________ State ____________ Zip __________Telephone: ________________________

*****Any questions call TPMRC-A 618-229-1420*****

Frequently Asked Questions: the following are questions frequently asked by GPMRC during the validation process. In order to speed up processing, please answer all of the following clinical information:

FLIGHT RESTRICTIONS:

- Max Stops: __ Unrestricted (stops allowed) ___ 1 thru 8 ____ ___ No Stops
  *Justification for No Stops____
- Max RONs: __ Unrestricted (stops allowed) ___ 1 thru 8 ___ ___ No RONS
  *Justification for No RONs____
- Altitude Restrictions: ___ None ___Sea Level ___500 thru 9000 ft _________
  *Justification for Altitude____

- ___ **Full Code** ___ **DNR/DNI** ***** additional forms required if patient is DNR/DNI*****
- Current pain level? With meds_____/ 10 Without meds ____/ 10
- Any air in the patient's skull/globe? ___**YES** ___**NO** If yes how much? ____________________________
- Date/Results of last CT/X-ray? ____
- TBI? ___**YES** ___**NO** **Mild** **Moderate** **Severe.** Current GCS ___/15
- Can pt clear ears in flight? ___**YES** ___**NO**
- Ambulatory? ___**YES** ___**NO**
- Motor deficits/Weight bearing restrictions? ___**YES** ___**NO**
  (List)____
- Communications barriers? ___**YES** ___**NO**
  (List)____
- Additional neuro deficits? ___**YES** ___**NO**
  (List)____
- Lab results (not listed on the 3899) pertinent to pt diagnosis: _____________________________________
  **(H/H below 10/30 must have standby O2 order on Section III or AF 3899 (reverse), Hgb ≤8 must have O2 ordered and cleared per Flight Surgeon.*
- IV's : Location_____________ Saline Lock: ___**YES** ___**NO**
  - Solution_____________ Rate____________
- Dressings – Type and location ____
  ____

****Orders for dressing changes must be annotated on Section III of AF 3899 (reverse) ****

- Ortho devices? / Special Equipment? **List all that will accompany patient to the destination facility (ex. wheelchair need to know if it is collapsible, weight and dimensions?) **
  ____
- For Psych diagnosis: SI/HI/AVH? ______ Contract for safety? ___**YES** ___**NO**. (If Yes **Please** attach a copy)
  Patient ever chemically or physically restrained? ___**YES** ___**NO** When, What, Where? ________________
  ____
  Is this the first admission for this diagnosis? ___**YES** ___**NO** Prev. Admission Date: ______________________

*****Any questions call TPMRC-A 618-229-1420*****

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 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	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 yes / no	Name, sex, weight, rank of attendents:	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:	O_2 /LPM:	Route:

Baseline O2 Sat if Applicable ______ Temp ____F

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)

						OTHER:
☐	Suction	☐	Traction	☐	Orthopedic devices	
☐	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 Lig 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

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:	
MEDICATION (*for PRN medications please put reason(s)):	

TRANSCOM PATIENT MOVEMENT REQUIREMENTS
CENTER- AMERICAS
USTRANSCOM SURGEON GENERAL
1600 SCOTT DRIVE
SCOTT AFB, IL 62208

MEMORANDUM FOR THE RECORD

Subj: CONSENT TO AERO-MEDICAL EVACUATION AND TRANSPORTATION

1. I have been advised that there may be associated risks to aero-medical evacuations, to include but not limited to decompression sickness, altitude sickness, hypoxia, motion sickness with associated nausea and vomiting and deep vein thrombosis.

2. Physiological effects of flight may include extremes of temperatures, low barometric pressure and vibrations.

3. The stresses of flight could potentially incite or aggravate the conditions listed above and could potentially lead to serious illness and/or death.

4. I am willing to accept these risks associated with my aero-medical evacuation and transportation.

5. Point of contact for this memorandum is Patient Movement Office at 618-229-1420/1679.

___________________________	___________________________
Signature/Date	Attending Physician Signature/Date
___________________________	___________________________
Printed Name	Printed Name or Stamp

____
Movement Signature/Date

____
Printed Name or Stamp

Patient Name: _____________________

AERO-MEDICAL EVACUTION

Additional Attendants Information

MEDICAL ATTENDANT(S) **(NOT LISTED ABOVE)**

Full Name (Last, First MI): ____

Full SSN: _____________________Date of Birth: ________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ___________________________ Position/Status to PT: __________________________

# of Bags & Description: ____

____

Full Name (Last, First MI): ____

Full SSN: _____________________Date of Birth: ________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ___________________________ Position/Status to PT: __________________________

# of Bags & Description: ____

____

Full Name (Last, First MI): ____

Full SSN: _____________________Date of Birth: ________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ___________________________ Position/Status to PT: __________________________

# of Bags & Description: ____

____

*****Any questions call Patient Movement Office 618-229-1420*****

NON-MEDICAL ATTENDANT(S) **(NOT LISTED ABOVE)**

Full Name (Last, First MI): ____

Full SSN: ______________________Date of Birth: _________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ____________________________ Position/Status to PT: _______________ __________

# of Bags & Description: ____

____

Full Name (Last, First MI): ____

Full SSN: ______________________Date of Birth: _________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ____________________________ Position/Status to PT: ___________________________

# of Bags & Description: ____

____

Full Name (Last, First MI): ____

Full SSN: ______________________Date of Birth: _________________Age: ________Weight:________ Lbs.

Unit Name & Duty Number: ____

Unit Address: ____

Home Address: ____

Phone/Cell Number: ____________________________ Position/Status to PT: ___________________________

# of Bags & Description: ____

____

*****Any questions call TPMRC-A 618-229-1420*****