|  |  |  |
| --- | --- | --- |
|  | **MEDICAL CLEARANCE**(to be completed or obtained from the attending physician) | MEDAConfidential if filled |
| Patient’s name |  |
| Date of birth |  | Gender |  |
| Height (metres) |  | Weight (Kgs) |  |
| **Diagnosis**(including date of current illness, episode of accident and treatment, specific contagious) |
|  |
| **Nature and date of any recent and/or relevant surgery** |
|  |
| **Additional clinical information**  |
| Respiratory condition  |
|  | Spontaneously | Mechanical ventilated | Intubated | Tracheostomy |
| IPPV | SIMV | BIPAP | CPAP |
| FiO2 | VT | f | PEEP | PIP |
|  |  |  |  |  |
| Oxygen needed during transport? | YES | NO |
| Oxygen needed specific flow O2 / min |  |
| Measurement of oxygen saturation  | YES | NO |
| **Cardiac condition:** |
|  | Heart rate | Blood pressure |
| /min | mmHg |
| Is the condition stable? | YES | NO |
| Myocardial infarction | YES | NO |
| Cardiac failure | NYHA | YES | NO |
| ECG  | YES | NO |
| If yes. What was the resolute? |  |
| ECG during transport? | YES | NO |
| Anemia | Give recent results in grams of hemoglobin |  |
| Continence Bladder control | If no, mode of control | YES | NO |
| **Neurologic condition** |
| GCS | Eyes | Verbal | Motor |
| 1 – Does not open eyes | 1 – Makes no sounds | 1 – Makes no movements |
| 2 - In response to painful stimuli | 2 - Incomprehensible sounds | 2 – Extension to painful stimuli |
| 3 – In response to voice | 3 – Utters inappropriate words | 3 – Abnormal flexion to painful stimuli |
| 4 - Spontaneously | 4 – Confused, disoriented | 4 – Abnormal flexion to painful stimuli |
| ------------------------------- | 5 – Normal oriented | 5 – Localizes painful stimuli |
| ------------------------------- | ------------------------------- | 6 – Obeys commands |
|  | Epilepsy | YES | NO |
| Can patient be agitated during transport? | YES | NO |
| Infection | YES | NO | Temperature: | Type of pathogen: |
| **Medication list:** |  |
| **Mobility** |
|  | Stretcher | YES | NO |
| Vacuum  | YES | NO |
| Air comfort stretcher / floating stretcher | YES | NO |
| WCHR – can walk well, but can use stairs | YES | NO |
| WCHS – cannot going up and down stairs | YES | NO |
| WCHC – cannot walk at all | YES | NO |
| Can walk well | YES | NO |
| **Medical assistant** |
| Patient have to be escorted by: |
| Physician | Nurse | Paramedic |
| Other medical information, nursing problems: |
|  |
| Prognosis for the trip | Good | Poor |
| **Patient has to be transported to:** |
| Hospital | Rehabilitation unit | Home | Other |
| Physician name |  |
| Hospital address |  |
| Telephone / Fax |  |
| E-mail address |  |
| Signature of physician |  | Date |  |
| Please fill in and send form tofax: +48 71 707 20 68 ou/or e-mail: biuro@specjal-trans.pl |
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