PATIENT TRANSFER BOOKING FORM

HOSPITAL DETAILS

Referring Hospital:	Doctor:

Ward:	Ward Contact:	Ward Ph:

Comments:

Receiving Hospital:	Doctor:

Ward and email address for invoicing:

PATIENT DETAILS

Name:	Address:
DOB:	Medical Condition:
Weight: BMI:	Comments:

Infectious Diseases:	Yes	No	Allergies:		
Patient to be transported from point of departure to airport by SKYMED	Yes	No	Patient to be transported from airport to destination by SKYMED	Yes	No
Stretcher Required:	Yes	No	Cardiac Monitor:	Yes	No
Patient Ambulant:	Yes	No	IV therapy:	Yes	No
O2 Therapy:	Yes	No	Diabetic:	Yes	No

TRAVEL DETAILS-Personal note

Go to bathroom before flight	Wear warm clothing and shoes	
Soft luggage bag	Packed lunch if appropriate	
Money for return journey	Ask if a relative can travel may be possible	