



Date Of Booking
____/____/____

AIR AMBULANCE TRANSFER / BOOKING FORM

Person Making Booking: Name: _____ Company: _____ Address: _____ _____ Post Code: _____ Tel No: _____	Patient Details: Name: _____ Address: _____ _____ Post Code: _____ Tel No: _____ Age: _____ G.P's Name: _____ Tel No: _____
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DOES THE PATIENT HAVE A MEDICAL NEED FOR AMBULANCE TRANSPORT? YES / NO

DOES THE PATIENT HAVE ANY OTHER REQUIREMENT BELOW:

EMERGENCY TRANSFER DETAILS	
Emergency Transfer: YES / NO	
Blue Lights To Be Used At Discretion Of Ambulance Crew: YES / NO	
Signed: _____	Position: _____

- Cardiac Condition
- I.T.U Patient
- Special Care Baby Unit
- I.V Fluids
- Heavy Patient (Over 15 Stone)
- Syringe Driver
- MRSA / Infection
- D.N.R Order
- Medical Team To Travel
- Medical Escort (Doctor / Nurse / Other)

Convey patient from: _____ _____ Post Code: _____ Terminal: _____ Flight No: _____ Date ____/____/____ Time ____am/pm	Convey patient to: _____ _____ _____ Post Code: _____ Ward / Dept: _____ Hospital _____
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REASON FOR JOURNEY (please tick appropriate box)
Hospital Admission Transfer Home Transfer To Nursing Home Other (please specify) _____

VEHICLE / JOURNEY TYPE (please TICK appropriate Crew Needed)
PTS Ambulance Paramedic Crew Ambulance EMT Ambulance Crew Nurse Escort Air Ambulance:

SPECIAL INSTRUCTIONS: (Please Add Any Relevent Information)

Who Will Be Paying Our EMS Invoice: Direct To Patient: <input type="checkbox"/> Direct To Booking Company: <input type="checkbox"/>	Transport Authorised By: _____ (Print Name)
Payments to be made in UK Pounds Sterling Only	Signed: _____ Date: _____
Office Use Only: Invoice No: _____ Invoice To: Patient / NHS / Other	