Severn Ambulance & Medical Services
A Voluntary Organisation Serving the Community

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SAF07 Medical Transfer Booking

Medical Transfer Booking Form

(To be completed in as much detail as possible; this will assist us in arranging your medical transfer.
Please note a booking form must be completed for each medical transfer unless otherwise agreed.)

Contact/Purchaser Details

Contact/Purchaser name: .....

Company/Organisation: .....

Position/Grade: .....

Contact address: .....
.....
.....
Post code: .....

Contact details:
Landline: .....
Mobile: .....
E-mail: .....

Invoice address: .....
(if applicable) .....
.....
Post code: .....

Order number: .....

Service User Details (refer to SA policy 1003)

Name .....

Date of Birth ...../...../.....

Estimated weight: .....kg

Reason for transfer: .....
.....
.....
.....
.....

On-going medical complaints:

……
……
……
……

On-going treatment/care required during transfer and any clinical needs likely to arise:

……
……
……
……
……

Level of mobility and details of any assistance required/current aids:

……
……
……
……
……

Has a risk assessment of the transfer been completed: Y / N (If yes this must be attached)

Do Not Attempt Resuscitation order in place Y / N (refer to SA policy 1001)

Advance Directive in place Y / N (refer to SA policy 1002)

Any special dietary requirements: (refer to SA policy 1004)

……
……
……

If nutritional needs are to be met who is to supply food/drink: (see below and SA policy 1004)

Service user / Severn Ambulance (please circle)

If Severn Ambulance is to provide food/drink, please state budget: £……
(All costs will be charged back to purchaser)

Itinerary for transfer

Address from: ……
……
……
Post code: ……

Destination address: ……
……
……
Post code: ……

Initial 'Pick-up' time: …… : …… 24hr clock Return journey: Y / N

Appointment time: Start: …… : …… 24hr clock Finish: …… : …… 24hr clock

Expected duration of journey: ……Hr ……Min (According to Google Maps™ Mapping Service)

Expected entire duration of transfer: ……Hr ……Min (refer to SA policy 1004 if >3hours)

Health & Safety

Location of service user within *from* address:

……

Details of any specialist extrication, ie: spiral staircase, no lift:

……
……
……

Has a risk assessment of the extrication been completed: Y / N (If yes this must be attached)

Accompanying persons

Number of persons to accompany service user: ……

If so: Name …….. Relation ……..
Name …….. Relation ……..

Will a medical team be accompanying the service user: Y / N

If so: Name …….. Skill ……..
Name …….. Skill ……..
Name …….. Skill ……..
Name …….. Skill ……..

Level of qualification for accompanying Severn Ambulance staff: (Please circle)
Registered Clinician / Ambulance Crew

Please attach any additional information you feel may be useful.

Signed: …… Position: ……

Name: …… Date: ……/……/……