Critical Care Needs Checklist – Pre Flight

Sending Facility________________________________ Date:______________

Pt's Name:____________________________________ Room #:__________

Height: _______________ Weight:____________________

Cardiac Monitor: Yes No ____________________

Isolation Precautions: Yes No ____________________

IV's

Medication	Rate		
___________	___________		
___________	___________	**OR**	**No IV's**
___________	___________		

Respiratory

O2 Liters/min Nasal Canula Face Mask Bi—pap

Ventilator Yes No

Settings Rate ___________

O2% ___________

Pressure Support ___________

Name______________________RN Signature_________________RN

Direct Nursing Station Phone #:__________________________

Fax to: 888-471-1656 or E-mail to airtrek@medjets.com

800-633-5387