ALASKA RESCUE COORDINATION CENTER
MEDICAL NECESSITY TRANSPORT FORM

Comm: (907) 551-7230 **Toll Free:** (800) 420-7230 **Fax:** (907) 551-7245 **E-mail:** ak.rcc@us.af.mil

Receiving Hospital:	Transport Date:	
On Scene Provider's Name:	On Scene Provider's Phone#:	
Receiving Provider's Name:	Receiving Provider's Phone#:	
Patient Name:	**Age:**	**Gender** M ☐ F ☐
Location:		

Immediate (within 8-12 hours) military transport is required to preserve life, limb or eyesight within a time period that civilian MEDEVAC company(s) are unable to respond ☐ Yes / ☐ No

Providers contacted / Response time:

☐ Life Med: _____ ☐ Guardian: _____ ☐ Life Flight: _____

☐ Air Lift NW: _____ ☐ 40 Mile: _____ ☐ Other: _____

Reason transport by commercial means is not available (i.e. weather, airfield conditions, aircraft availability patient size):

VITALS

Describe the MEDICAL CONDITION (physical and/or mental) of this patient that requires the patient to be transported in DoD assets:

Time / Date of injury or onset of symptoms							
Time Taken		B/P		Pulse		Temperature	
Conscious	☐ Yes ☐ No	Ambulatory	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No	Vomiting	☐ Yes ☐ No
Signs of Shock	☐ Yes ☐ No Type/Extent:					SPO2	
Paralysis	☐ Yes ☐ No Extent:						
Bleeding	☐ Yes ☐ No Extent:						
Eyes	☐ Dilated ☐ Reactive ☐ Equal			Pregnant	☐ Yes ☐ No Number of weeks?		

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SAMPLE (Signs/Symptoms, Allergies, Medications taking/given, past medical history, last oral intake, events leading to incident):

Special Equipment / Medication needed? Who will provide?

Requesting non-medical passengers OR civilian medical providers transported on DOD aircraft: ☐ Yes / ☐ No
Explain and provide name(s) (i.e. family members, nurses, law enforcement):

Is there law enforcement concerns? ☐ Yes / ☐ No If yes, explain:

Additional Remarks/Information:

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires immediate transport or will likely result in **loss of life, limb, or eyesight**. I understand that this information will be used by the Alaska Rescue Coordination Center to support the determination of medical necessity for DoD services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician or Healthcare Professional	Printed Name of Physician	Date