North East
Mobile Health Services

Physician's Orders for Interfacility Transport

Place patient label here or:

Patient Name: ________________________

Date of Birth: ________________________

Transport Date: ______________________ **Diagnosis:** ______________________

Patient Weight: ______________________ **Allergies:** ______________________

Resuscitation Status

☐ Full	☐ POLST	☐ DNI	☐ DNR

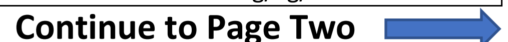
Patient Acuity

☐ Stable, No-Risk	☐ Stable, Low Risk	☐ Stable, Medium Risk	☐ Stable, High Risk	☐ Unstable

Transport Orders

Level		Order	Details
EMT	☐	Oxygen	☐ NC ☐ NR to maintain O2 Sat of ___________
EMT	☐	Vital sign / Neuro Check	☐ 5 min ☐ 10 min ☐ 15 min ☐ 30 min ☐ 1 hr
EMT	☐	Saline Lock Only	
EMT	☐	Non-Medicated Fluids	☐ LR ☐ NS *No Pump, rate set by sending facility
EMT	☐	Behavioral Restraint	Blue/White Paper order required
EMT	☐	Medical Restraint	Soft Restraints
EMT	☐	PCA Pump	With No Continuous infusion Medication: ___________________________
EMT	☐	Patient Centric Device	Describe: ____
EMT	☐	Spinal Precautions	Spinal restriction during transport with a stretcher in low semi-fowlers
AEMT	☐	Non-Medicated Fluids	☐ LR ☐ NS @ ______ ml/hr via IV pump
AEMT	☐	Cardiac Monitor	Non-Cardiac Diagnosis
AEMT	☐	CPAP	FiO2:______ PEEP:______
AEMT	☐	Acetaminophen	______ mg via ☐ IV ☐ PO q ______
AEMT	☐	Albuterol	Nebulized q ______
AEMT	☐	Albuterol/Ipratropium	Nebulized q ______
AEMT	☐	Ondansetron	4 mg via ☐ IV ☐ ODT q ______
Paramedic	☐	Cardiac Monitoring	A cardiac-related diagnosis that will require EKG interpretation
Paramedic	☐	Full ACLS Protocol	
Paramedic		**Pain Management**	
Paramedic	☐	Fentanyl	______ mcg/kg ☐ IV ☐ IM q ______
Paramedic	☐	Ketamine	______ mg/kg ☐ IV ☐ IM q ______
Paramedic		**Sedation/Anticonvulsant**	
Paramedic	☐	Midazolam	______ mg via ☐ IV ☐ IM q ______
Paramedic		**Other Medications**	
Paramedic	☐	D10	______ ml/hr via IV pump
Paramedic	☐	Diphenhydramine	______ mg IV q ______ (Additional vials may be needed for repeat doses)
Paramedic	☐	Dexamethasone	______ mg IV q ______ (Additional vials may be needed for repeat doses)
Paramedic	☐	Magnesium Sulfate	______ g IV q ______
Paramedic	☐	NOREPInephrine	8mg in 250 ml NS @ ______ mcg/kg/min to maintain SBP <______ Titrate 0.03 mcg/kg/min every 3-5 minutes. Max dose 3 mcg/kg/min

Continue to Page Two



Physician's Orders for Interfacility Transport

Place patient label here or:

Patient Name: ______________________

Date of Birth: ______________________

Transport Date: ______________________________

PIFT			
	Medications (Not listed previously or in ACLS) Medications listed here will need to be provided to the crew for transport. **See the list of allowed medication classes below**		
	☐	Esmolol	______ ml/hr titrate for desired rate of ____________
	☐	Heparin	______ units/kg/hr | ________ ml/hr @ ______________ concentration
	☐	Labetalol	______ mg IV q ______ to maintain SBP range of __________________
	☐	Nicardipine	______ ml/hr titrate to maintain SBP range of ____________________
	☐	Nitroglycerin	______ mcg/min | ______ ml/hr
	☐	Oxymizer	_____ lpm to maintain O2 Sat of _____
	☐	PCA with continuous infusion	Medication: _________________ @ ______ ml/hr
	☐		
	☐		
	Procedures		
	☐	Central Line	
	☐	Continuous Bladder Irrigation	
	☐	Chest Tube to water seal	
	☐	Chest tube to Heimlich valve	
	☐	OG/NG clamped or to suction	
	☐	Transvenous pacemaker	
	☐	Wound Vac	Non-Patient Centric

PIFT ALLOWED MEDICATION CLASSES

- Anticoagulants
- Anticonvulsants
- Antidiabetics
- Antidysrhythmic
- Antihypertensives
- Anti-infectives
- Antipsychotics
- Cardiac Glycosides
- Corticosteroids
- Drotrecogin
- GI Agents
- Medicated IV Fluids, Electrolytes
- Narcotics (*all routes except epidural)*
- OTC (*as part of care plan)*
- Parenteral Nutrition & Vitamins
- Platelet Aggregation Inhibitors
- Respiratory Medications
- Sedatives
- Vasoactive Agents

SCT				
	☐	Blood/Blood Product Infusion	Requires RN	
	☐	Fetal Monitoring	Requires RN	
	☐	Mechanical Vent	Requires RT or Vent Trained Nurse	Vent Settings ________________ ☐ HOB 15 degrees ☐ Sedation/Pain med
	☐	Paralytics / Propofol	Requires RN	

Ordering Physician

By signing below, I authorize the identified procedures and medications as indicated above. I acknowledge that the resources provided during interfacility transportation are appropriate for this patient. In the event of a medical emergency during transport, I authorize the full use of the Maine EMS Pre-Hospital Protocols to treat and stabilize this patient.

____________	____________	X ______________________________	______________________________
Date	Time 24 hour	Signature of Physician or Designee	Printed Name

Medical Control Call Back #:_________________________