Tasmanian Government

Non-Emergency Patient Transport (NEPT) Licensing
Ambulance Service Act 1982

FORM 10B
PATIENT CARE RECORD

PT ID									

SURNAME..... D.O.B .....
OTHER NAMES.....
ADDRESS .....
.....

Attach Patient Sticker Label

NEPT SERVICE:_____

BARCODE TBA

Transport Details			
Pick Up Location	**NEPT Crew**		
Pick Up Actual Date: DD / MM / YYYY Time: 00 : 00 *(24 hr)*	Crew Member Name/s	Quals/Role	Initials
Destination Location			
Destination Arrival Date: DD / MM / YYYY Time: 00 : 00 *(24 hr)*			

Patient Representative	**Clinical Escort**		
Name	Clinical Escort Name	Quals/Role	Initials
Relationship to patient			
Contact details			

An NEPT crew member must **NOT** accept a patient for transport without a copy of the Form 10A Patient Assessment Record for that patient (r.9), which must be attached to this Form 10B to form an approved Patient Care Record (r.30).

Patient History *(Complete and confirm from the attached Form 10A)*

A Primary Diagnosis *(print)*:	**B** Relevant Comorbidities *(print)*:
C Existing conditions that may predispose patient to harm *(print)*:	**D** Current care or treatments *(print)*:
E Allergies *(print)*:	**F** Patient Acuity Level *(print)*:

If an NEPT crew member believes a patient is not suitable for NEPT (r.10), or does not have the required equipment or crew (r.9), the NEPT crew member **MUST REFUSE** to transport the patient.

NEPT Clinical Assessment Record

Assessing NEPT Crew Member *(print name)*:			Date: DD / MM / YYYY Time: 00 : 00 *(24 hour)*
Pain *(tick)*: **Yes** ☐ **No** ☐ If Yes, Score (*1 to 10*):	Last analgesia dose and time *(specify)*:	Analgesia required for transport? **Yes** ☐ **No** ☐ If Yes, specify:	If **diabetic**, last BSL *(specify)*:
Clinical Equipment *(tick)*: ☐ Oxygen _____ L/min via _____ ☐ Cannula *(note site)* _____ ☐ Drain *(note site)* _____ ☐ Other *(specify)*:	**Colour** *(circle)*: Pink | Pale | Grey Other *(specify)*:	**Mobility status** *(tick)*: ☐ Ambulant ☐ Needs Assistance ☐ Other *(specify)*:	**Transport mode** *(tick)*: ☐ Stretcher ☐ NEPT seat ☐ Wheelchair ☐ Other *(specify)*:
Cognitive status *(specify)*:	**Vision** *(tick)*: ☐ Glasses, wearing/with patient ☐ Contact lenses ☐ Other *(specify)*:	**Hearing** *(tick)*: ☐ Hearing aid in situ ☐ Reduced hearing ☐ Other *(specify)*:	**Dentures** *(tick)*: ☐ In situ ☐ Carried with patient ☐ Other *(specify)*:

Clinical Observations of Vital Signs (as required)

Time *(24 hr)*	Resp rate	SaO2	Colour	Pulse	Blood Pressure	Temperature	Pain *(1 to 10)*	Alert and cooperative?
00 : 00								
00 : 00								
00 : 00								
00 : 00								

If patient's medical condition changes during transport, a crew member must contact Ambulance Tasmania (call 000) for consultation with an AT clinician and comply with any AT instructions (r.13).

Patient Care Report *(print)*

Reason NEPT ceased:
(for example discharged to receiving service)

Discharge from NEPT Service

Clinical Handover provided by NEPT Crew Member *(print name)*:	Location	Date: DD / MM / YYYY Time: 00 : 00 *(24 hour)*
Clinical Handover received by	Location	Signature

FORM 10B PATIENT CARE RECORD

TASMANIAN HEALTH SERVICE

Tasmanian Government

FORM NAME

FACILITY:_____

PT ID									

SURNAME..... D.O.B .....
OTHER
NAMES.....

Attach Patient Sticker Label

ADDRESS .....

.....

(print name):		

FORM NAME