



VASCULAR SERVICES

A service of Mercy Medical Center—Des Moines

Acute Limb Ischemia Transfer Data Sheet			Patient Name: _____		
			DOB: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date:			Past Medical History		
Hospital:			<input type="checkbox"/> Major Surgery (past 6 months)		
Height:		Weight:	<input type="checkbox"/> Trauma (past 30 days)		
Allergies: <input type="checkbox"/> Contrast allergy			<input type="checkbox"/> Bleeding disorders		
			<input type="checkbox"/> Stroke (past 6 months)		
			<input type="checkbox"/> Cancer/neoplasm		
			<input type="checkbox"/> Pulmonary disorders		
Symptom Onset:			<input type="checkbox"/> Diabetes		
ED Arrival:			<input type="checkbox"/> Chronic kidney disease (Cr>2)		
Presenting Symptoms:					
Diagnostic Tests - send with patient					
<input type="checkbox"/> Ultrasound			Past Cardiac History		
<input type="checkbox"/> CT Scan <i>send CD with patient</i>			<input type="checkbox"/> MI	<input type="checkbox"/> PCI	<input type="checkbox"/> CABG
<input type="checkbox"/> Echo			<input type="checkbox"/> CHF	<input type="checkbox"/> A Fib	<input type="checkbox"/>
<input type="checkbox"/> EKG			<input type="checkbox"/> PPM	<input type="checkbox"/> ICD	<input type="checkbox"/>
<input type="checkbox"/> CXR					
<input type="checkbox"/> Lab			Protocol Medications		
Hgb	Hct	Cr	Heparin		
PT	INR	PTT			
<input type="checkbox"/> Urine HCG on women 12-50 years of age					
Time Diagnosis Confirmed:					
One Call Transfer Time:					
Transport Arrival:					
ED Exit:			Current Medications		
Transport					
<input type="checkbox"/> Air <input type="checkbox"/> Ground					
Patient Condition					
<input type="checkbox"/> Stable		<input type="checkbox"/> Cardiogenic Shock			
<input type="checkbox"/> CPR		<input type="checkbox"/> VT/VF			

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