

Protected A (when completed)

**STRATEGIC AEROMEDICAL EVACUATION (AE) REQUEST**

SECTION A – PATIENT INFORMATION		
Name:		Patient ID: (if applicable)
Rank:		SN:
Sex: Gender:		DOB:
Parent unit:		MOC/MOSID:
Move Window (Date/Time patient can be moved)		
Earliest:		Latest:
Originating Medical Facility (OMF)		
Name of OMF:	Ward	
	Phone	
Attending/Referring Physician:	Phone	
	Email	
Referring CAF Physician:	Phone	
	Email	
Administrative Point of Contact at OMF:	Phone	
	Email	
Destination Medical Facility (DMF)		
Name of DMF:	Ward	
	Phone	
Attending/Receiving Physician:	Phone	
	Email	
Receiving Base/Wing Surgeon:	Phone	
	Email	
Administrative Point of Contact at DMF:	Phone	
	Email	
SECTION B – MISSION INFORMATION		
Priority		Additional AE crew required: (AE crew consists of one Flight Nurse, one Flight Med Tech and one Flight Surgeon) Specify:
Classification		Special equipment required: Specify:
Dependency		Altitude restrictions: Specify:
		NOK accompanying: Name:

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