SITUATION ROOM Covid-19
sitroom@sswhg-hse.ie - www.sswhg-hse.ie
021/420 5661 - 021/420 5671
South/South West Hospital Group

REQUEST FOR ASSISTANCE IN TRANSFER OF A LOW ACUITY PATIENT

1. REQUESTING HOSPITAL

NAME :	**DATE: TIME:**
GRADE/TITLE	
CONTACT NUMBER :	**EMAIL ADDRESS:**
REQUESTING HOSPITAL:	
ADDRESS OF HOSPITAL:	

2. STARTING LOCATION OF TASK

GPS or EIRCODE
ADDRESS:
POINT/PERSON TO CONTACT:
TELEPHONE AND EMAIL:

3. DESTINATION AND DURATION OF TASK

START DATE AND TIME:
ESTIMATED COMPLETION TIME:
DESTINATION OF PATIENT: **GPS/EIRCODE:** **ADDRESS:** **CONTACT PERSON AT DESTINATION:** **CONTACT NUMBER:** **E.MAIL.**
ALL RELEVANT INFORMATION FOR BRIEFING OF AMBULANCE CREW :

4. **SITUATION ROOM ACTION**

TIME RECEIVED AT SITUATION ROOM:
ACCEPTANCE / CLARIFICATION OF TASKING: (If Necessary):
COMMNICATE TO IAEMO FOR ACTION:
SITUATION ROOM **LOG/ SIGN DTG:**

5. **ACTION BY IAEMO**

TIME RECEIVED BY IAEMO:
VES DESIGNATED FOR TASKING :
INFORMATION PASSED TO VES :
VES REPORTS TASKING COMPLETE:
ANY ISSUES ARRISING:
REPORT COMPLETION TO SITUATION ROOM :

6. **ACTION BY SITUATION ROOM**

TASK LEARNING:
FILE REFERENCE DTG: **SIGANTURE:**