Annexure 4*: HEALTH HELP CENTRE (HHC) AMBULANCE TRIPSHEET *(to be documented in the health facility)

<table>
<tr><td colspan="5">HOSPITAL NAME:</td><td colspan="4">PATIENT DETAILS</td></tr>
<tr><td colspan="5" rowspan="2"></td><td colspan="2">Victim Name:</td><td rowspan="2">Age/Sex</td></tr>
<tr><td colspan="5">Victim ID*</td><td colspan="2"></td></tr>
<tr><td colspan="5">Type of trip</td><td colspan="4">Victim ID*</td></tr>
<tr><td rowspan="2">Type of trip</td><td rowspan="2">EMS</td><td colspan="3">Inter facility transfer</td><td colspan="4">Caller Phone No.:</td></tr>
<tr><td>EL</td><td>EM</td><td>CCT</td><td colspan="4" rowspan="3">Incident Location:</td></tr>
<tr><td>Event Date:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Event ID*</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Ambulance No*</td><td></td><td></td><td></td><td></td><td colspan="4">Name of Doctor:</td></tr>
<tr><td>Assign Time*</td><td colspan="4"></td><td colspan="4">PATIENT ASSESSMENT DETAILS</td></tr>
<tr><td>Departure time*</td><td colspan="4"></td><td colspan="4">Alert/verbal/pain/Unresponsive</td></tr>
<tr><td>Scene Arrival Time*</td><td colspan="4"></td><td>Time</td><td>On scene</td><td>2nd Time</td><td>3rd Time</td></tr>
<tr><td>Scene Departure Time*</td><td colspan="4"></td><td>PR/min</td><td></td><td></td><td></td></tr>
<tr><td>Hospital reach Time*</td><td colspan="4"></td><td>BP(mmHg)</td><td></td><td></td><td></td></tr>
<tr><td>Patient Admitted Time*</td><td colspan="4"></td><td>RR/min</td><td></td><td></td><td></td></tr>
<tr><td>Amb. Release Time*</td><td colspan="4"></td><td>Temp</td><td></td><td></td><td></td></tr>
<tr><td>Star Odometer (KM)</td><td colspan="4"></td><td>SPO2(%)</td><td></td><td></td><td></td></tr>
<tr><td>End Odometer(KM)</td><td colspan="4"></td><td>RBS(mg/dl)</td><td></td><td></td><td></td></tr>
<tr><td colspan="9">CASE SUMMARY :</td></tr>
</table>

Medical Direction/Advice

Details of Medical Care Given

Handed over by:
Designation:
Name & Signature Name & Signature of Patient/Attendants
Date:

Received By:
Designation:
Name& Signature:
Hospital:
Date: