



HUDSON VALLEY REGIONAL
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Helicopter Transport Incident Report

This form is to be filled out and forwarded to the HVREMAC Helicopter Committee in the event that there is a deviation or complication to effective transfer of care from ground Emergency Services to Aero Medical Services.

Date of Incident: _____ **NYS PCR #:** _____
(If known)

Time of Incident: _____ **Estimated Ground Transport Time:** _____
(To nearest appropriate hospital)

Time of Helicopter Request: _____ **Estimated Time of Arrival Given:** _____

Time Helicopter Enroute: _____ **Time Helicopter Orbiting Scene:** _____

Time Flight Crew Began Care: _____ **Time Patient Loaded on Helicopter:** _____

Time Helicopter Enroute to Hospital: _____ **Destination:** _____
(If Known)

Location of Incident: _____

Type of Individual Initiating Request: _____
(i.e., EMT, Paramedic, Fire Chief etc.)

Dispatch Entity Requesting Helicopter: _____

Helicopter Service Involved: _____

Other Agencies or Parties Involved: _____

Describe Incident: _____

(Attach additional information if necessary)

Name: _____ **Title/Position:** _____

Contact Number: () _____ - _____ **E-Mail:** _____

Signature: _____ **Date:** _____

Date Received: _____ **For Office Use Only** _____ Reviewed By: _____