South Dakota Department of Health
Trauma System

Local Emergency Medical Service Trauma Transportation Plan

INSTRUCTIONS: Complete this form, attach copies of all required documentation, and return to:

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Trauma System Manager
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Use the tab button to move from field to field

Please Note: All required criteria must be met before submitting application – (R) Required

Date: (R)

Type: Initial Renewal

Name of Service: (R)

Mailing Address: (R)

Physical Address if different from above: (R)

City (R): County: State: Zip Code:

Physician Medical Director: (R)

Service Director or Manager: (R)

Phone Number: (R)

E-mail Address:

Name of person completing plan if different from above: (R)

Service Information:

Number of runs per year:

Volunteer Paid Combination

City County ☐ Hospital Other

Number of ambulances

Does the service have an emergency helicopter landing zone in the response area? Yes No

Does the service participate in any hospital performance improvement programs? Yes No

Does the service assist any hospital with education or outreach programs? Yes No

Personnel:

Number of EMTs:

Number of EMT-I or AEMTs:

Number of Paramedics:

Do the personnel that are licensed at a level above EMT-B have the necessary protocols and equipment to properly give care at that level? Yes ☐ No ☐
If no, please explain.

Number of EMS Providers that have taken PHTLS:

Number of EMS Providers that are current in PHTLS:

Other Resources: (R)

(Rugged, technical or special rescue agencies; haz-mat or biohazard decontamination units.)

Additional Resources: (R) (List all mutual-aid resources that are available with-in your response area including: ground EMS, first responder units, quick response units, rescue and extrication units, air medical, both rotor and fixed wing.)

Triage/MCI:

Does the service have the following triage equipment available?

EMSC triage fanny packs on each ambulance — Triage tags on each ambulance

Equipment to establish a treatment area — Other

Does the service practice/train with triage/MCI equipment at least once per year? Yes No

Does the service have an established triage/MCI protocol? Yes No

Does the service have access to the following items for use during an MCI event?

Yes	No	
		Extra standard x-ray translucent backboards
		One-time use/disposable backboards
		Extra C-Collars/Head immobilizers
		Extra splinting devices
		Extra wound care supplies

Additional info:

Hospital Organizations within local transport area: (R)
(Those facilities that you would transport to.)
(Please note any facility that has a helicopter landing area on site.)

Hospital Organizations that your service transfers to regularly: (R)
(Include those that receive your patients by ground or by air.)

Map of Service Area: (R)

(Attach an image of your response area. If transportation decisions differ by area, divide map into response zones. See example on trauma website. http://www.doh.sd.gov/trauma/EMS.aspx**)**

Transport Protocol by zone: (R)

(Explain the transportation plan for severely injured trauma patients by zone listed above. See example on trauma website. http://www.doh.sd.gov/trauma/EMS.aspx**)**

Transport Decisions: (R)

1. Does the service have the ability, if available, to request ALS air assistance to the scene of a major trauma patient? Yes ☐ No ☐

   If yes, what is the process for this request and who is notified? If no, please explain.

2. Does the service have the ability, if available, to request ALS ground assistance, Fire, Search and Rescue, or other appropriate agencies to the scene of a major trauma patient?

ALS	Yes ☐	No ☐	Fire	Yes ☐	No ☐
S & R	Yes ☐	No ☐	Other	Yes ☐	No ☐

   If yes, what is the process for this request and who is notified? If no, please explain.

Transport Decisions (cont.): (R)

3. Does the service have the ability to make decisions in the field that will ensure the patient will receive definitive care in the least amount of time? Examples include: choosing to transport to a trauma hospital with more resources over another with less resources, requesting ALS air assistance be dispatched to the hospital prior to patient arrival, and requesting an en-route intercept with an EMS service with a higher level of care. Yes ☐ No ☐

   If yes, what is the process for these requests and who is notified? If no, please explain.

4. Does the service have the ability, if available, to have ALS ground or air assistance, Fire, Search and Rescue, or other appropriate agencies automatically dispatched for certain types of trauma incidents. These would be incidents identified by MOI, incident location, or reports of injuries from first responders.

   ALS Yes ☐ No ☐ Fire Yes ☐ No ☐
   S & R Yes ☐ No ☐ Other Yes ☐ No ☐

   If yes, please list the services and indicators for this to occur. If no, please explain.

Signatures: (R)

Ambulance service director or chief officer:

Name:
Organization:
Signature: ____ Date:

Ambulance service medical director:

Name:
Organization:
Signature: ____ Date:

Trauma Program Manager of all local hospitals listed in plan:

Name:
Organization:
Signature: ____ Date:

Name:
Organization:
Signature: ____ Date:

Name:
Organization:
Signature: ____ Date:

Ambulance service director of any service listed as intercept or auto-dispatch:

Name:
Organization:
Signature: ____ Date:

Name:
Organization:
Signature: ____ Date:

Name:
Organization:
Signature: ____ Date:

Additional Information:

SD DOH Trauma Program office use only
Approved: Date: Follow-up Date:
Notes: