APPROACH AND LANDING GUIDELINES

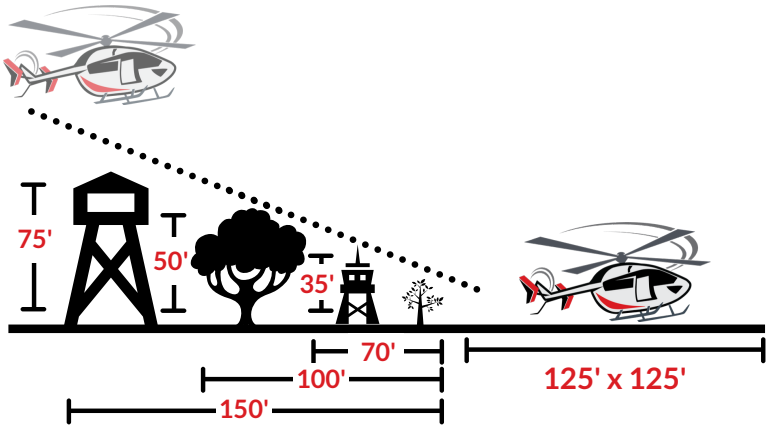
LANDING ZONES

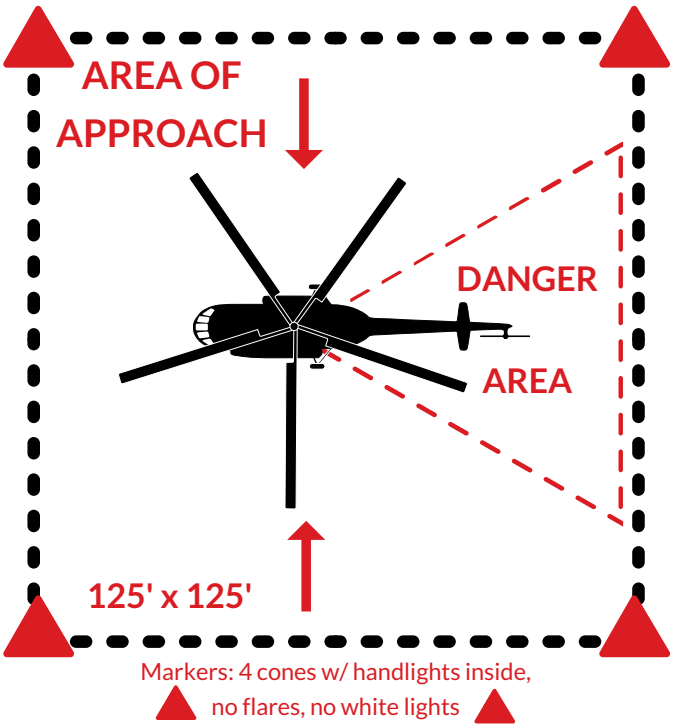
- REQUESTS
  - Standby
  - Launch
- LANDING ZONE
  - 125ft x 125ft
  - Flat or trim surface
  - Free of overhead obstacles
  - Closest street address, intersection or milemarker
- LANDING ZONE COMMAND
  - Low Band, VHF or UHF
  - 1 point of contact for aircraft
  - Brief LZ description with any cautions or hazards
  - Ensure crowds stay back

APPROACHING AIRCRAFT

- Charged handlines not required
- "ABORT, ABORT, ABORT" over radio if hazards arise at any point
- Stay clear of tail rotor
- No Smoking within 200ft of aircraft
- Do not approach aircraft without flight crew

GLIDE PATH CONSIDERATION





FOR TRANSPORTS CALL

1-800-743-4375

CALL EARLY FOR STANDBY

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Your nonprofit air medical program serving the Finger Lakes, Central and Mohawk Valley regions of NY.

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camts Commission on Accreditation of Medical Transport Systems

GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

1 Measure Vital Signs and Level of Consciousness

Glasgow Coma Scale	≤ 13
Systolic Blood Pressure	< 90 mmHg
Respiratory Rate	<10 or >29 breaths per minute or need for ventilatory support (<20 in infant <1 year)

YES → **TRANSPORT TO TRAUMA CENTER. Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.**

NO

2 Assess Anatomy of Injury

- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

YES → **TRANSPORT TO TRAUMA CENTER. Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.**

NO

3 Assess Mechanism of Injury & Evidence of High-Energy Impact

- Falls
  - Adults >20 feet (one story = 10 feet)
  - Children: >10 feet or 2-3x the height of the child
- High-risk auto crash
  - Intrusion including roof >12 inches occupant site >18 inches any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with a high risk of injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph

YES → **TRANSPORT TO TRAUMA CENTER. Which, depending upon the defined trauma system, need not be the highest level trauma center.**

NO

4 Assess Special Patient or System Considerations

- Older Adults
  - Risk of injury/death increases after age 55
  - SBP<110 may represent shock after age 65
  - Low impact mechanisms (e.g. ground level falls) may result in severe injury
- Children
  - Should be triaged preferentially to pediatric capable trauma centers
- Anticoagulants and bleeding disorders
  - Patients with head injury are at high risk for rapid deterioration
- Burns
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center
- Pregnancy >20 weeks
- EMS provider judgement

YES → **TRANSPORT TO TRAUMA CENTER or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.**

TRANSPORT ACCORDING TO PROTOCOL

When in doubt, transport to a trauma center.

*Source: CDC Guidelines of Field Triage 2011