

Air Medical Services (AMS) Guidelines

For all first responders and EMS agencies serving the Hudson Valley & Westchester EMS Regions



INTRODUCTION

The Hudson Valley–Westchester Helicopter subcommittee is an inter-regional advisory group established by the Hudson Valley and Westchester Regional EMS Councils and the local Air Medical Services (AMS). This guideline is provided to all emergency service agencies: law enforcement, fire departments, and emergency medical services (EMS) in the lower seven counties of the Hudson River Valley (geographically north to south, west to east) – Sullivan, Ulster, Dutchess, Orange, Putnam, Rockland, and Westchester.

The helicopter is an air ambulance and an essential part of the EMS system. In today's environment of increasingly scarce EMS resources, appropriate use of AMS is of the utmost importance. Adherence to the practices included in this guideline will help to ensure that the proper resources are provided to the right patients at the right time while maintaining safe and efficient EMS operations.

OPERATIONAL CRITERIA FOR REQUESTING AIR MEDICAL SERVICES

The following operational criteria must be met prior to requesting a helicopter for scene response:

1. The patient can arrive at the closest appropriate facility faster by air than by ground transport.
2. A safe helicopter-landing site is available.

Ground providers should notify dispatch if more than one patient requires air transport. If available, one helicopter will be dispatched per critical patient requiring air transport.

CLINICAL CRITERIA FOR REQUESTING AIR MEDICAL SERVICES

1. The patient needs and/or would benefit from the clinical capability of the AMS team.
2. A patient in cardiac arrest may be transported by AMS if already responding and the transport to the closest hospital would be faster by air than ground.

NEW YORK STATE CRITERIA FOR REQUESTING AIR MEDICAL SERVICES

Requesting AMS follows the New York State Department of Health (NYSDOH) Bureau of EMS (BEMS) published Policy 05-05: Guidelines for Helicopter Utilization Criteria for Scene Response (attached below). <http://www.health.ny.gov/professionals/ems/pdf/05-05.pdf>



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates: **New**

No. 05-05
Date: 9/12/05
Re: Guidelines for Helicopter Utilization Criteria for Scene Response

Page 1 of 3

Purpose:

Air Medical Services (AMS) are a valuable, yet limited resource in New York State. It is important that Emergency Medical Service Personnel utilize consistent and appropriate criteria when requesting an air medical service for assistance with patient care and transport. The following represents a combination of the current criteria in use throughout the state. These criteria are consistent with national AMS utilization criteria. It is important that review of appropriate helicopter utilization be a part of EMS training, as well as a component of the agency and regional level retrospective quality assurance process.

Criteria:

1. The helicopter is an air ambulance and an essential part of the EMS system. It may be considered in situations wherein:
 - The use of the helicopter would speed a patient's arrival to the hospital capable of providing definitive care and this is felt to be significant to the patient's condition, or;
 - If specialized services offered by the air medical service would benefit the patient prior to arrival at the hospital.
2. The following criteria should be used when considering use of an air medical service:
 - The patient's condition is a "life or limb" threatening situation demanding intensive multidisciplinary treatment and care. This may include but not be limited to:
 - Patients with ***physical findings*** defined in the adult and pediatric major trauma protocols (see attached)
 - Critical burn patients (see attached)
 - Critically ill medical patients requiring care at a specialized center to include, but not be limited to: acute stroke or ST elevation MI as defined by NYS protocol (see attached); and/or
 - ***Patients in cardiac arrest who are not hypothermic should be excluded from these criteria***
3. Dispatch, Police, Fire or EMS will evaluate the situation/condition and if necessary, may place the helicopter on standby.
4. The helicopter may be requested to respond to the scene when:
 - ALS personnel request the helicopter.
 - BLS personnel request the helicopter, when ALS is delayed or unavailable.
 - In the absence of an EMS agency, any emergency service may request the helicopter, if it is felt to be medically necessary.

5. When EMS arrive, they should assess the situation. If the MOST HIGHLY TRAINED EMS PERSONNEL ON THE SCENE determines, that the helicopter is not needed, it should be cancelled as soon as possible.
6. When use of air medical services is not specifically defined by the protocol, the on scene EMS provider should establish communication with medical control to discuss the situation with the on line physician.
7. Air medical services may be considered in situations where the patient is inaccessible by other means or, if utilization of existing ground transport services threatens to overwhelm the local EMS system.
8. The destination facility will be determined by the AMS crew based upon medical appropriateness with consideration for patient preference and on line medical direction, in compliance with regional protocols.
9. An EMS service should not wait on the scene or delay transport waiting for the helicopter to arrive. If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital and reassign the landing zone. The helicopter may intercept with an ambulance during transport at an alternate-landing site.

THIS IS A GUIDELINE AND IS NOT INTENDED TO SPECIFICALLY DEFINE EVERY CONDITION IN WHICH AIR MEDICAL SERVICES SHOULD BE REQUESTED. EMS PERSONNEL SHOULD USE GOOD CLINICAL JUDGEMENT SHOULD BE USED AT ALL TIMES

Transfer of Patient Care, Documentation and Quality Assurance:

- As with other instances where care of a patient is transferred, it is expected that all patient related information, assessment findings and treatment will be communicated to the flight crew.
- At the completion of the EMS call, all of the details of the response, including, but not limited to all patient related information, assessment findings and treatment must be documented on a Department approved Patient Care Report (PCR).
- As with all EMS responses, helicopter utilization, the treatment and transportation of patients will be reviewed as a part of a Quality Assurance process.

ADULT MAJOR TRAUMA

1. GCS less than or equal to 13
2. Respiratory Rate less than 10 or more than 29 breaths per minute
3. Pulse rate is less than 50 or more than 120 beats per minute
4. Systolic blood pressure is less than 90mmHg
5. Penetrating injuries to head, neck, torso or proximal extremities
6. Two or more suspected proximal long bone fractures
7. Suspected flail chest
8. Suspected spinal cord injury or limb paralysis
9. Amputation (except digits)
10. Suspected pelvic fracture
11. Open or depressed skull fracture

PEDIATRIC MAJOR TRAUMA

1. Pulse greater than normal range for patient's age
2. Systolic blood pressure below normal range
3. Respiratory status inadequate (central cyanosis, respiratory rate low for the child's age, capillary refill time greater than two seconds)
4. Glasgow coma scale less than 14
5. Penetrating injuries of the trunk, head, neck, chest, abdomen or groin.
6. two or more proximal long bone fractures
7. flail chest
8. combined system trauma that involves two or more body systems, injuries or major blunt trauma to the chest or abdomen
9. spinal cord injury or limb paralysis
10. amputation (except digits)

CRITICAL BURNS

1. Greater than 20% Body Surface Area (BSA) second or third degree burns
2. Evidence of airway/facial burns
3. Circumferential extremity burns

**Note that for patients with burns and coexisting trauma, the traumatic injury should be considered the first priority and the patient should be triaged to the closest appropriate trauma center for initial stabilization.

CRITICAL MEDICAL CONDITIONS

1. Suspected acute stroke
 - Positive Cincinnati Pre-hospital Stroke Scale
 - Total prehospital time (time from when the patient's symptoms and/or signs first began to when the patient is expected to arrive at the Stroke Center) is less than two (2) hours.
2. Suspected Acute Myocardial Infarction
 - Chest pain, Shortness of breath or other symptoms typical of a cardiac event
 - EKG findings of
 - ST elevation 1mm or more in 2 or more contiguous leads
 - OR
 - LBBB (QRS duration >.12msec and Q wave in V1 or V2)

ESTIMATED TIME OF ARRIVAL (ETA) vs. ACTUAL TIME OF ARRIVAL (ATA)

Upon request for air medical transport, the dispatch center will issue an Estimated Time of Arrival (ETA). If the ETA is greater than the time needed to secure and transport the patient to the closest appropriate facility by ground ambulance, transport should be completed by ground ambulance.

Once a helicopter is airborne, the air medical team will communicate an updated ETA to the County Emergency Communications Center (ECC) to communicate to the scene personnel. As the helicopter nears the scene, the air medical team will attempt to contact the ground personnel as well. If the updated ETA provided by the helicopter is greater than the time needed to secure and transport the patient to the closest appropriate facility by ground ambulance, transport should be completed by ground ambulance.

The Actual Time of Arrival (ATA) is when the helicopter has reached the location of the scene (at high orbit). All communications and times should be recorded by scene personnel for their records, especially when care of the patient was transferred to the air medical team.

DISPATCH CENTER STAND-BY CRITERIA

A “stand-by” procedure may be requested by any local dispatch center to the appropriate County ECC based upon the report of the following:

- Gas or other type explosion;
- Severe burn injury;
- Motor vehicle crash with high mechanism;
- Motor vehicle crash involving an all-terrain vehicle (ATV), motorcycle, ejection of passenger, or pedestrian struck;
- Penetrating trauma;
- Falls from a significant height;
- Any incident with the potential of producing mass casualties;
- Any additional criteria determined appropriate and agreed upon by decision-makers at the Public Safety Answering Points.

Under these circumstances:

1. The appropriate County ECC will contact the air medical dispatch center to have the AMS “stand-by”.
2. The County ECC will notify responding Emergency Services that an AMS “stand-by” has been requested.
3. Once Emergency Services have arrived and assessed the patient, the highest trained EMS provider on the scene will determine whether to launch or cancel AMS.
 - a. In the event that additional information that meets criteria for AMS activation is gained via communications or other means, the request to respond may be made prior to Emergency Services arrival to minimize ETA.
4. This determination will be communicated to the County ECC, including reasons for cancellation if such occurs.
5. The County ECC shall notify the air medical dispatch center as soon as it is determined from the scene whether or not AMS is needed, with the reason if cancelled.

AIR MEDICAL SERVICES AIRBORNE STANDBY

Due to the size of the area covered in the lower Hudson River Valley by AMS and the flight time to reach the edges of the service area, an "Airborne Standby" procedure will be used based upon the following:

1. Upon request to place AMS on "stand-by", the air medical dispatch center will determine the estimated distance (in nautical miles) from the assigned AMS unit to the incident scene;
2. If the incident scene is greater than or equal to twenty five (25) nautical miles (approximately a twelve minute flight time) away from the assigned AMS unit, the helicopter will launch in the direction of the incident and notify the county ECC that they are on an airborne standby;
3. The air medical dispatch center will then notify the requesting County ECC of the AMS status;
4. As soon as it is determined from the scene that the AMS is or is not needed, the requesting County ECC shall notify the air medical dispatch center along with the reason for the cancellation;
5. If AMS arrives at the scene prior to the utilization decision, AMS will maintain a holding pattern a safe distance from the scene pending notification to land or depart.

SCENE SAFETY

Landing Zones

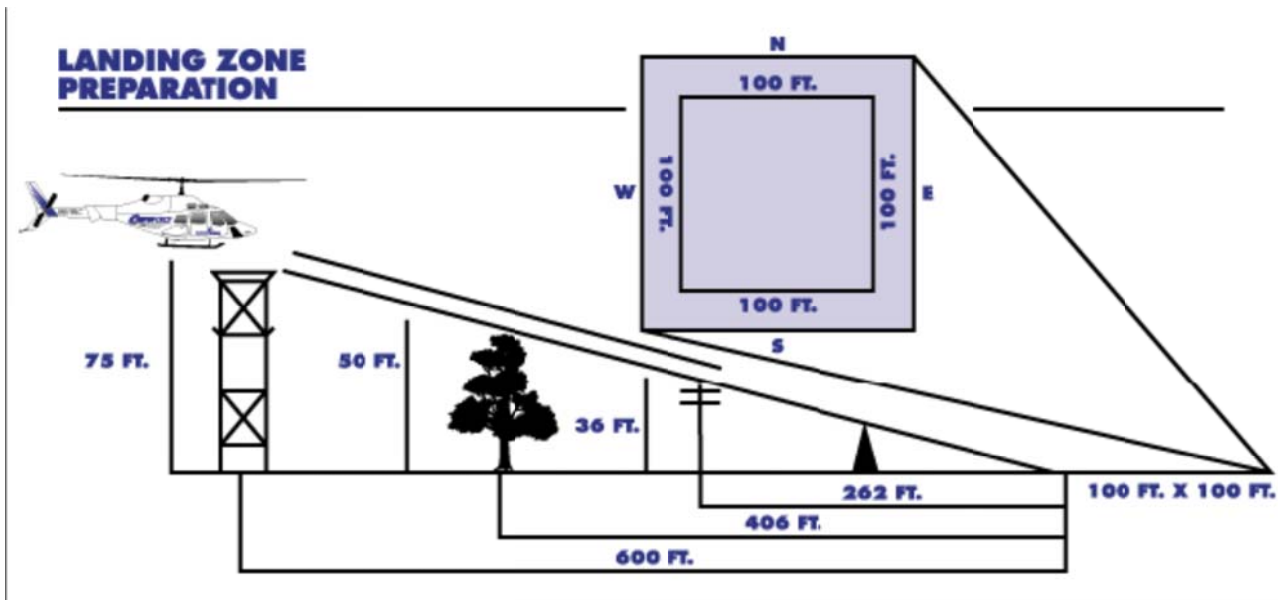
The landing zone (LZ) should be adjacent to the scene to avoid the need for additional intermediate ground transport that would prolong a patient's out-of-hospital time. The helicopter should land as close to the scene as possible and practical. When a hospital's helipad is determined to be the most appropriate landing zone to effectuate field transfer of a patient from EMS to AMS, the County ECC shall notify the hospital as soon as possible. The use of a hospital helipad to rendezvous EMS and AMS does not trigger an EMTALA obligation for the hospital.

LZ Criteria

- 100 feet by 100 feet
- Free of overhanging obstructions;
- Generally level (Slope should not be greater than 5 degrees);
- On a firm surface (If unpaved, shrubs, brush, grass or weeds should be less than 24 inches in height).

Marking the LZ

Mark the four corners of the LZ with orange traffic cones, preferably. The use of flares for marking the LZ is discouraged because of the inherent fire risk. For night operations, a flashlight can be placed in each cone for illumination. The cones will likely blow over as the aircraft makes its final approach into the LZ and are too heavy to be drawn into the rotor system.



Landing Zone Safety and Crowd Control

Landing zones at scenes, day or night, must be secure prior to the pilot commencing an approach. Confirmation of a secured landing zone should always include two-way radio communication with ground personnel. If two-way radio communication is not available, the pilot shall visually check for landing zone security during the high reconnaissance maneuver.

To maintain a safe environment when operating into a landing zone, one of the following procedures will be utilized:

- Aircraft will be shutdown. At any time when the security of the scene is in question, and/or no positive crowd control is actively in place, one crew member shall remain in the vicinity of the aircraft and provide scene security until the pilot shuts down the aircraft.
- Aircraft power will be reduced to ground idle or a reduced power setting as specified in the Aircraft Flight Manual. Altitude / Auto Trim mode shall be off and SAS mode selected if appropriate. Controls will be secured in one of the following manners, positively locked, force trim on or frictioned as not to move. The pilot will get out of the aircraft and guard the area around the aircraft. The pilot shall stay within the rotor diameter of the aircraft.
- Aircraft power will be reduced to ground idle or a reduced power setting as specified in the Aircraft Flight Manual, pilot will stay in seat in cockpit, and a trained crewmember will guard the area around the aircraft.
- Aircraft power will be reduced to ground idle or a reduced power setting as specified in the Aircraft Flight Manual, pilot will stay in seat in cockpit, and a trained crewmember will brief a first responder, such as a law enforcement officer or fireman. After being briefed, the person briefed will ensure that no one approaches the aircraft without the knowledge of the pilot.
- The contents of the briefing that the crewmember will give to the appropriate first responder is as follows:
 - Stay at least 50 feet from aircraft.
 - Do not allow anyone to approach the aircraft without permission from the pilot or a crewmember.
 - Anyone that approaches the aircraft must be accompanied by a crewmember.
 - Crew will assign personnel to help carry the stretcher to the aircraft.
 - Remember to exit in the same direction that you approached the aircraft.

Landing zone debris considerations:

- Approaches will be made to the ground whenever possible.
- Avoid hovering at the scene.
- Takeoffs should be made directly from the ground.

A tail rotor guard may be utilized; this individual will be briefed by the Pilot in Command (PIC) or properly trained medical personnel/crewmembers. However, the PIC retains responsibility for safety around the aircraft, this responsibility cannot be delegated.

Loading and Unloading Patient / Passengers

The loading or unloading of passengers or patients while the rotors are turning is only allowed if the pilot and/or properly trained medical person is outside the helicopter to guide and direct anyone who approaches the aircraft. Ground personnel will not come beneath the rotor disc until directed to do so by the PIC. The pilot and/or properly trained medical person must be constantly alert to prevent anyone from coming near the tail rotor. The pilot should only be used if flight controls can be locked in place or frictioned so as not to move.

Whenever practical, the loading and unloading of passengers or patients will be done with rotors not in motion. Patient condition and a consensus of the pilot and medical personnel/crewmembers will determine if the helicopter may be enplaned/deplaned with rotors turning. In all cases, the PIC determines whether enplaning/deplaning with rotor turning will or will not be accomplished.

Whenever the helicopter has landed to pick up passenger(s) or patient(s) and when practical, the pilot shall position the aircraft so that the tail rotor is away from the area that people are expected to approach the helicopter. For aircraft equipped with a rotor system that has a forward tilt, or that has a low clearance at the front; these aircraft shall be positioned so that all personnel movement will be to or from the 3 or 9 o'clock positions.

The Helicopter may be enplaned or deplaned with rotors turning provided:

- The rotor tip path plane is leveled.
- IV poles and other equipment shall be kept at head height or lower.
- The controls are secure.
- The autopilot is off. (If autopilot is installed)
- The force trim is on. (If force trim is installed)
- Engine RPM is at ground idle.
- The pilot will use appropriate hand signals when directing ground personnel to approach the aircraft.

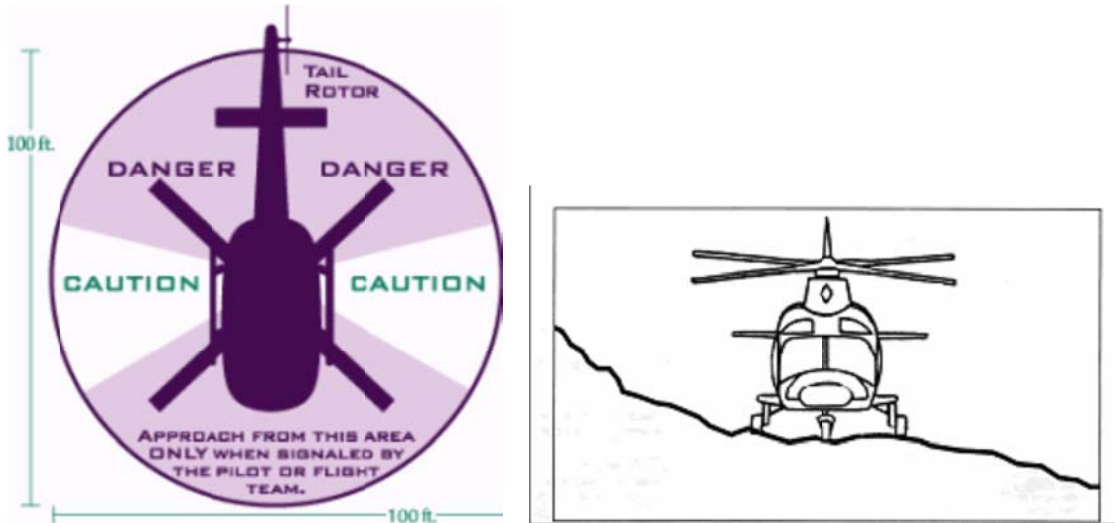
The following terminology shall be utilized:

- **Hot offload/offloading:** Indicates that the helicopter will be deplaned with engines running and rotors turning.
- **Hot on load/loading:** Indicates that the helicopter will be enplaned with engines running and rotor turning.
 - It is recommended that the pilot not assist in physically loading the patient.
- **Cold offload/offloading:** Indicates that the helicopter will be deplaned with engines shutdown and rotors completely stopped.
- **Cold on load/loading:** Indicates that the helicopter will be enplaned with engines shutdown and rotor completely stopped.

Post-Landing Operations

Once a helicopter has landed, the following should be observed:

- Assure that no one approaches the helicopter or enters the LZ unless directed to do so by the flight team.
- Never allow a vehicle to drive up to the helicopter.
- If you are directed to approach the helicopter by the flight team, **NEVER** approach the rear of the helicopter, only approach from the front. The tail rotors are invisible when spinning.



Patient Loading

The flight team will ask for four (4) responders to assist in carrying and loading the stretcher into the aircraft after the patient has been prepared. Follow the flight team's direction when carrying the patient toward the aircraft. Please do not allow more than four (4) responders to assist in the carry unless directed to by the flight team. Once the patient has been loaded into the helicopter, exit the LZ by the same direction that you used to enter. Never attempt to operate any of the aircraft doors or the stretcher-securing device.

Patient "Hot" Off-Loading

When a patient is off loaded from the aircraft while the rotors are turning and engines remain running, it is classified as a "hot" off-load and requires the following:

1. Aircraft medical crew determine that a "hot" off-load will be necessary;
2. Notification is made to the air medical dispatch center from the medical crew that a "hot" off load will be necessary;
3. Air medical dispatch center will alert the receiving hospital Emergency Department of the aircraft's "hot" off load status;
4. A member of the aircraft crew or medical team must be in position at the tail rotor prior to hospital personnel approaching the aircraft.

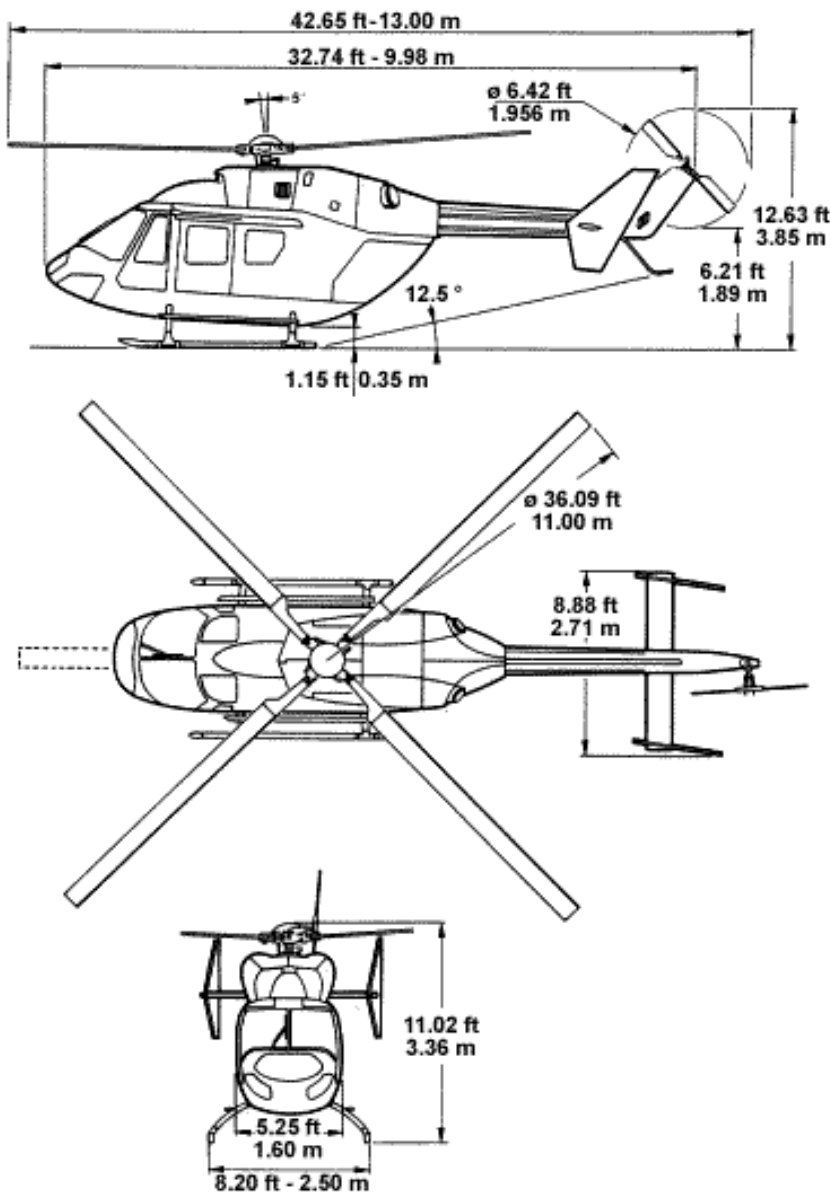
A patient may be "hot" off-loaded for the following reasons:

1. Patient with failed airway;
2. Patient in extremis;
3. Adverse weather consideration;
4. Pending mission.

Aircraft Differences

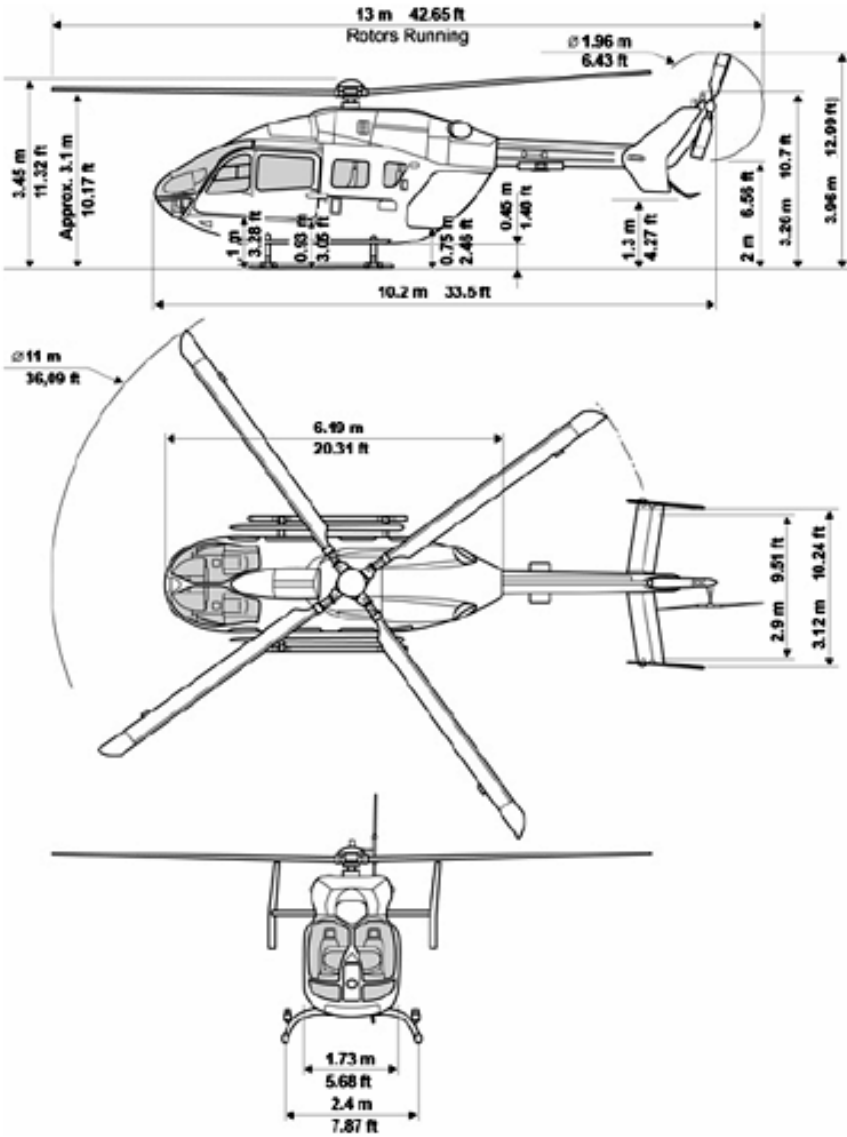
The following airframes are used by local AMS with their unique aspects described: BK-117, EC-135, EC-145, AS-350 (A-star), Bell 430.

BK-117



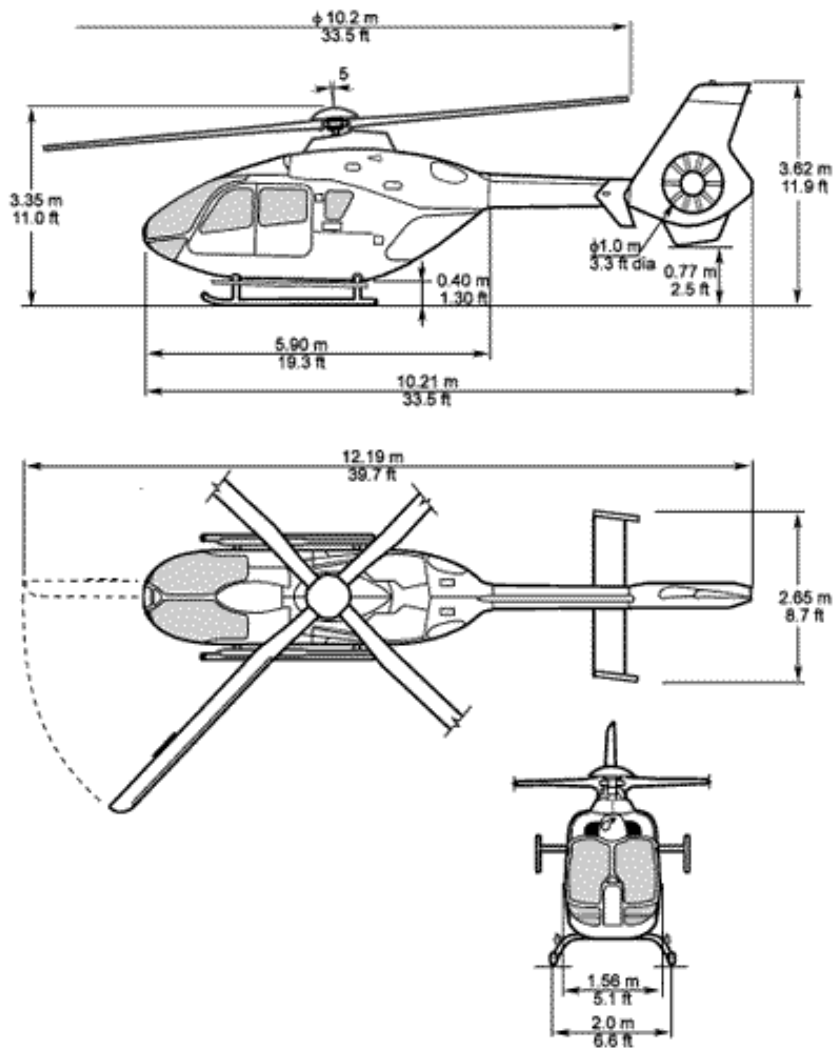
- Medium twin engine aircraft
- Only approach aircraft with permission of Flight Crew
- Approach from front of aircraft / Load patient from rear clam-shell doors
- Danger Zones include:
 - Tail rotor area
 - Engine(s) exhaust area
 - Main rotor (consider slope)
- Tail Rotor Guard ALWAYS Required!

EC-145



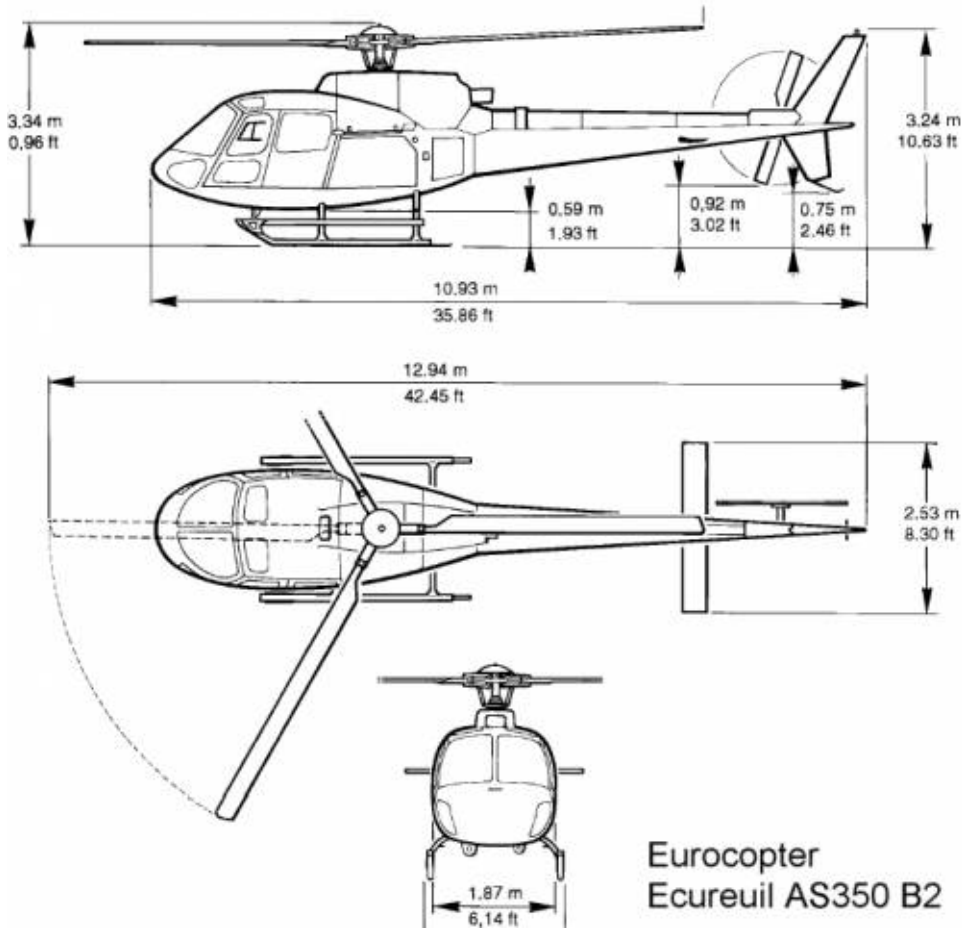
- Medium twin engine aircraft
- Only approach aircraft with permission of Flight Crew
- Approach from front of aircraft / Load patient from rear clam-shell doors
- Danger Zones include:
 - Tail rotor area
 - Engine(s) exhaust area
 - Main rotor (consider slope)
- Tail Rotor Guard ALWAYS Required!

EC-135



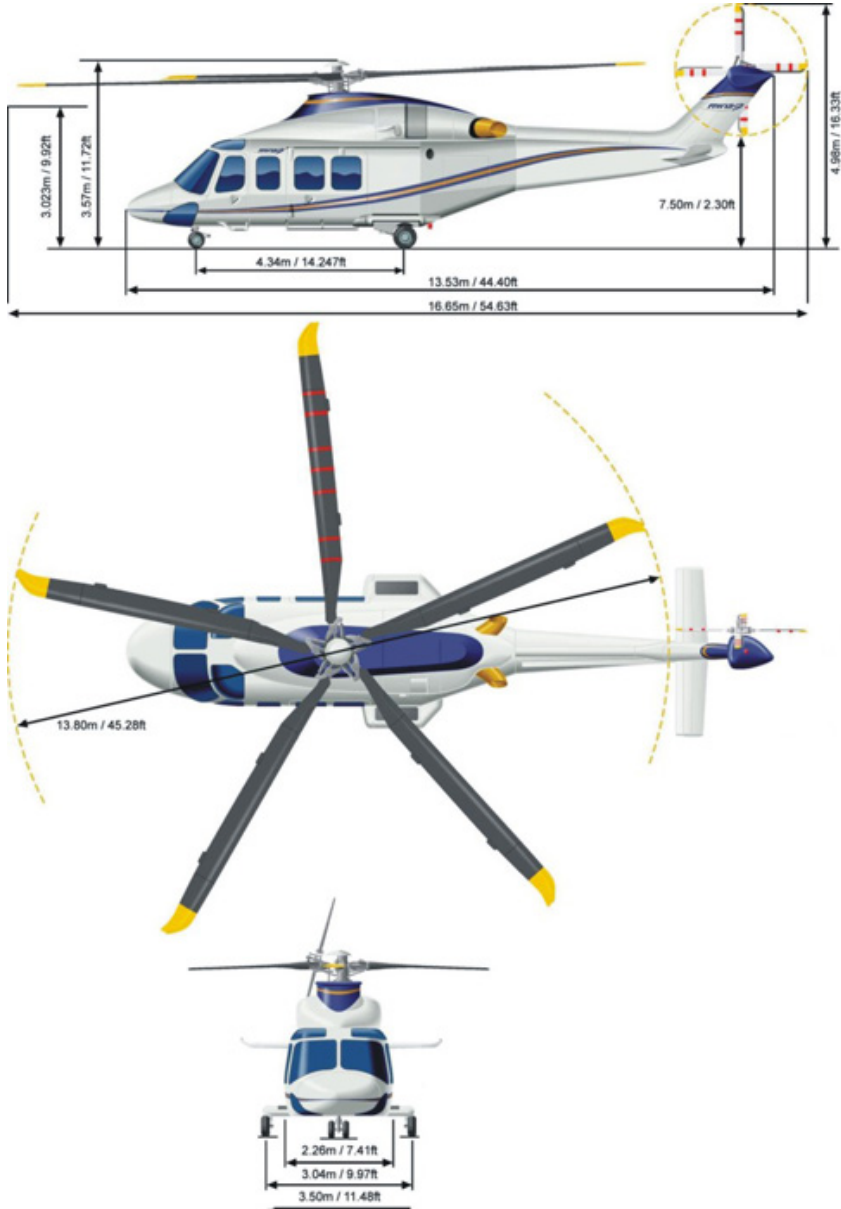
- Medium twin engine aircraft
- Only approach aircraft with permission of Flight Crew
- Approach from front of aircraft / Load patient from rear clam-shell doors
- Danger Zones include:
 - Tail rotor area
 - Engine(s) exhaust area
 - Main rotor (consider slope)
- Tail Rotor Guard ALWAYS Required!

AS-350



- Single engine aircraft
- Only approach aircraft with permission of Flight Crew
- Approach from front of aircraft / Load patient from Left side of Aircraft
- Danger Zones include:
 - Tail rotor area
 - Engine(s) exhaust area
 - Main rotor (consider slope)
- Tail Rotor Guard ALWAYS Required!

AW-139



- Twin engine aircraft
- Only approach aircraft with permission of Flight Crew
- Approach from front of aircraft / Load patient from side doors
- Danger Zones include:
 - Tail rotor area
 - Engine(s) exhaust area
 - Main rotor (consider slope)
- Tail Rotor Guard ALWAYS Required!

REPORTING INCIDENTS

Note: *The New York State Department of Health Bureau of EMS (NYSDOH BEMS) mandates specific incident reporting responsibilities and requirements for all EMS services. Incidents identified must be reported as indicated in NYCRR, Part 800, Section 21(q) 1-5 and Section 21(r), Part 80, 80.136 (k), NYSDOH BEMS Policy Statement 98-11, as well as other applicable state and regional policies and procedures.*

Regional complaints or concerns involving air medical services may be made by a patient, the public, participating organizations or individual providers. All such complaints or concerns should be brought to the attention of the Executive Director of the appropriate Regional EMS Council. Complaints will be forwarded to the Regional Emergency Medical Advisory Committee's Evaluation Subcommittee for review. The Helicopter Subcommittee shall review all complaints regarding AMS operational issues and act in an advisory capacity to the Evaluation Subcommittee for all other reviews.

AIR MEDICAL SERVICES INCIDENT REPORT FORM

Forward the completed form to the appropriate Regional EMS Council in the event that there is a deviation from or complication of effective transfer of care from ground EMS to AMS.

Contact Information

Name		Title	
Contact #		Email	
Signature		Date	

Incident Information

Date of Incident:						NYS PCR #:	
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Air Medical Service Involved:	
Other Agencies / Parties Involved:	
Requested By (e.g., EMT, Fire Chief, etc.)	
Requesting Dispatch Entity	
Location of Incident:	
Destination (if known):	

Describe Incident : *(Attach additional information if necessary)*

Call Times

Time of Incident:					
AMS Requested:					
AMS Enroute:					
AMS Orbiting Scene:					
Flight Crew Began Care:					
Patient Loaded on aircraft					
AMS Enroute to Hospital:					
ETA of AMS Given:	()	Minutes		
ETA to Hospital by Ground:	()	Minutes		

For Regional EMS Office Use Only

Date Received:

Reviewed By:

AIR MEDICAL BASE OPERATIONS BY SERVICE

NOTE: The location of each base operation is being provided to offer an understanding of the distances covered by each agency. When air medical services are requested, the **CLOSEST** available helicopter will be dispatched to respond to the emergency. Depending on factors such as weather conditions at the base locations or a commitment to another mission, “local” services may be unavailable and an air medical service from outside of the lower Hudson Valley River Valley or even out of state may be the closest available.

Helicopter	Service	Base Location	Airframe	Air Medical Dispatch Entity
LifeNet Air 2	Air Methods, LifeNet of New York	Kobelt Airport Walkill, NY (Ulster County)	EC-135 EC-145	AirCom
LifeNet 7-5	Air Methods, LifeNet of New York	Catskill Regional Medical Center Harris, NY (Sullivan County)	AS-350	AirCom
Hackensack UMC AirMed One	Hackensack University Medical Center	Greenwood Lake Airport West Milford, NJ	EC-135	MICCOM
ATLANTIC AIR ONE	Atlantic Health System / Atlantic Ambulance Corp	Netcong, NJ	EC-135	Cencom
LifeNet 7-1	Air Methods, LifeNet of New York	South Albany Airport Selkirk, NY (Albany County)	EC-135	AirCom
LifeGuard **Rescue and Extraction Only**	New York State Police / Colonie EMS	Albany County Airport Albany, NY	Bell 430	AirCom
NORTH STAR	New Jersey State Police / University Hospital	Somerset Airport Somerset, NJ	AW-139	Regional Emergency Medical Communication System (REMCS)
LIFE STAR 2	LifeStar	Hartford Hospital Hartford, CT	BK-117 EC-145	Hartford Hospital ECC
SkyHealth **Interfacility to Yale / Bridgeport Only**	Yale New Haven Hospital / North Shore – Long Island Jewish Health System	Long Island Jewish Hospital Manhasset, NY –or– Bridgeport Hospital Bridgeport, CT	EC-135	Y Access Line

911 RECEIVING HOSPITALS BY COUNTY

Burn Center	Burn
Hyperbaric Medicine	HM
Helipad	HP
Level 1 (Regional) Trauma Center	RTC
Level 2 (Area) Trauma Center	ATC
Neonatal Intensive Care	NICU
Obstetrical	OB
Pediatric Intensive Care	PICU
Percutaneous Coronary Intervention Center	PCI
Stroke Center	ST

NOTE: Prior to transport, hospital capabilities should be verified by on-scene EMS personnel directly with on-line Medical Control or through the county ECC.

See also: http://profiles.health.ny.gov/hospital/county_or_region/

Dutchess	Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST
Northern Dutchess Hospital	Rhinebeck						•			•
Mid-Hudson Regional Hospital of WMC	Poughkeepsie	•	ATC						•	•
Vassar Brothers Medical Center	Poughkeepsie	•				•	•	•	•	•
Orange	Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST
Bon Secours Community Hospital	Port Jervis									
Keller Army Community Hospital	West Point	•								
Orange Regional Medical Center	Middletown	•				•	•	•	•	•
St. Anthony Community Hospital	Warwick						•			
St. Luke's Cornwall Hospital - Cornwall Campus	Cornwall	•								•
St. Luke's Cornwall Hospital - Newburgh Campus	Newburgh	•				•	•			•
Putnam	Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST
Putnam Memorial Hospital	Carmel						•			•
Rockland	Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST
Good Samaritan Hospital	Suffern	•	ATC			•	•	•		•
Nyack Hospital	Nyack		ATC			•	•			•

911 RECEIVING HOSPITALS BY COUNTY- cont'd

See also: http://profiles.health.ny.gov/hospital/county_or_region/

Sullivan										
Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST	
Catskill Regional Medical Center	•					•				
Catskill Regional Medical Center	•									
Ulster										
Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST	
Ellenville Community Hospital	•									
Health Alliance of the Hudson Valley						•			•	
Westchester										
Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST	
Montefiore – Mount Vernon Hospital								•	•	
Montefiore – New Rochelle Hospital									•	
New York-Presbyterian/Hudson Valley Hospital Center					•	•			•	
New York-Presbyterian/Lawrence Hospital					•				•	
Northern Westchester Hospital					•				•	
Phelps Memorial Hospital									•	
St. John's Riverside Hospital – Andrus Pavilion									•	
St. John's Riverside Hospital – Dobbs Ferry Pavilion										
St. Joseph's Medical Center									•	
Westchester Medical Center	•	RTC	•	•	•	•	•	•	•	
White Plains Hospital Center					•		•		•	
Out of Region										
Location	HP	Trauma	Burn	PICU	NICU	OB	PCI	HM	ST	
Sharon Hospital	•					•			•	
Albany Medical Center	•	RTC		•	•	•	•	•	•	
Jacobi Medical Center	•	RTC	•	•	•	•	•	•	•	