



PATIENT EVACUATION TRACKING FORM

1. DATE 2. UNIT

3. PATIENT NAME 4. AGE 5. MR#

6. DIAGNOSIS(-ES) 7. ADMITTING PHYSICIAN

8. FAMILY NOTIFIED
[ ] Yes [ ] No Contact Information:

9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)
[ ] Hospital Bed [ ] IV Pump(s) [ ] Isolette/Warmer [ ] Foley Catheter
[ ] Gurney [ ] Oxygen [ ] Traction [ ] Halo-Device
[ ] Wheel Chair [ ] Ventilator [ ] Monitor [ ] Cranial Bolt/Screw
[ ] Ambulatory [ ] Chest Tube(s) [ ] A-Line/Swan [ ] IO Device
[ ] Other [ ] Other
Isolation [ ] Yes [ ] No Type
Reason

10. EVACUATING CLINICAL LOCATION 11. ARRIVING LOCATION
Room # Time Room # Time
ID Band Confirmed [ ] Yes [ ] No ID Band Confirmed [ ] Yes [ ] No
By: By:
Medical Record sent [ ] Yes [ ] No Medical Record received [ ] Yes [ ] No
Addressograph sent [ ] Yes [ ] No Addressograph received [ ] Yes [ ] No
Belongings [ ] with patient [ ] left in room [ ] none Belongings received [ ] Yes [ ] No
Valuables [ ] with patient [ ] left in safe [ ] none Valuables [ ] Yes [ ] No
Medications [ ] with patient [ ] left on unit [ ] to pharmacy Medications received [ ] Yes [ ] No
PEDS/INFANTS
Bag/Mask with tubing sent [ ] Yes [ ] No Bag/Mask with tubing received [ ] Yes [ ] No
Bulb Syringe sent [ ] Yes [ ] No Bulb Syringe received [ ] Yes [ ] No

12. TRANSFERRING TO ANOTHER FACILITY
Time to Staging Area Time Departing to Receiving Facility
Destination
Transportation [ ] Ambulance unit [ ] Helicopter [ ] Other:
ID Band Confirmed [ ] Yes [ ] No By:
Departure Time

13. FACILITY NAME

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR PATIENTS TRANSFERRED TO ANOTHER FACILITY.
ORIGINATION: INPATIENT UNIT LEADER, OUTPATIENT UNIT LEADER AND/OR CASUALTY CARE UNIT LEADER. ORIGINAL TO: PATIENT.
COPIES TO: PATIENT TRACKING MANAGER, MEDICAL CARE BRANCH DIRECTOR AND EVACUATING CLINICAL LOCATION. HICS 260