**Final 12-20-2021**

**PURPOSE:** The HICS 260 - Patient Evacuation/Transfer Tracking Form documents details and account for patients evacuated/transferred to another facility.

**ORIGINATION:** Completed by the Operations Section as appropriate: the Inpatient Unit Leader, the Outpatient Unit Leader, or the Casualty Care Unit Leader, depending on where the identified patient is located.

**COPIES TO:** The original is kept with the patient through actual evacuation/transfer. Copies are distributed to the Patient Tracking Manager, the Medical Care Branch Director, the evacuating/sending clinical location, and the Documentation Unit Leader.

**NOTES:** The information on this form may be used to complete HICS 255, Master Patient Evacuation Tracking Form. Additions or deletions may be made to the form to meet the organization’s needs.

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| **NUMBER** | **TITLE** | **INSTRUCTIONS** |
| **1** | **Date** | Enter the date of the evacuation/transfer. |
| **2** | **From** | Enter the Hospital and Unit the patient is leaving from. |
| **3** | **Patient Name** | Enter the patient’s full name. |
| **4** | **Medical Record Number** | Enter the patient’s medical record number. |
| **5** | **DOB/Age/Weight** | Enter the patient’s date of birth (DOB), Age, Weight |
| **6** | **Diagnosis** | Enter the primary diagnosis/diagnoses. |
| **7** | **Family/Friend Notified** | Enter the name, relationship/ and contact information of the family/friend notified. |
| **8** | **Mode of Transport** | Identify mode of transportation used. |
| **9** | **Accompanying Equipment** | Check appropriate boxes for any equipment being transferred with the patient. |
| **10** | **Triage Category** | Indicates Level of Transport needed. |
| **11** | **Isolation** | Indicate if isolation is required, the type, and the reason. |
| **12** | **Evacuating/Transferring Clinical Location** | Fill in information and check boxes to indicate Sending Physician and contact number, room #, time, ID Band confirmed by; and what was sent with the patient (medical records, belongings, valuables, medications). Attach Medication List if available. |
| **13** | **Arriving Location** | Fill in information and check boxes to indicate Receiving Physician and contact number, room #, time, and ID band confirmed by; and whether materials sent with patient were received. |
|  | **PEDS/INFANTS** | Document Appropriate BVM with Tubing and Bulb Syringe and any other specialty equipment sent/received |
| **14** | **Transferring to another Facility/ Destination (name)** | Document destination, name, address, point of contact, phone number, arrival time in the staging area, time loading completed, type of transportation used, name of agency, ID band confirmed departure time, transfer center and contact number, sending hospital confirmation sent: yes/no. |
| **16** | **Prepared by** | Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility. |
|  | **Sending Facility Patient Label or Bar Code** | Attach patient’s current facility patient label if available or Tracking Bar Code if available |