|  |  |  |
| --- | --- | --- |
| **1. Date** | **2. From** (Hospital/Address): | **Unit** |
| **3. Patient Name** | **4. Medical Record Number** |
| **5. DOB** | **Age** | **Weight** | **6. Diagnosis** |
| **7. Family/Friend Notified** (Relationship) | [ ]  YES [ ]  NO NAME: CONTACT INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **8. Mode of Transport:** | **9. Accompanying Equipment** (check those that apply below): |
| [ ]  Hospital Bed[ ]  Crib[ ]  Isolette/Warmer[ ]  Gurney | [ ]  Wheelchair[ ]  Ambulatory[ ]  Evacuation Device[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Bag/Mask with Tubing Sent[ ]  CPAP/BiPAP[ ]  Ventilator, Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Arterial Line / Swan[ ]  # Volume Pump(s)\_\_\_\_\_\_\_\_\_\_\_[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Cardiac Monitor[ ]  Pulse Oximetry  (stand-alone)[ ]  Traction[ ]  Other \_\_\_\_\_\_\_\_\_ |
| **10. Triage Category** [ ]  Minimal/Moderate Acuity/ALS Transport & Care[ ]  Stable/No Injury/Non-EMS Transport/Discharge [ ]  Moderate/Critical acuity/ALS Transport & Care [ ]  Stable/Low acuity/BLS Transport & Care [ ]  Severe/Critical acuity/ALS Transport & Care |
| **11. Isolation** **[ ]** YES [ ]  NO TYPE: REASON:  |
| **12. Evacuating/Transferring Clinical Location** | **13. Arriving Location** |
|  **Sending Physician and Contact #** |  **Receiving Physician and Contact #** |
| **ROOM #** |  **TIME** | **ROOM # TIME** |
| **ID BAND CONFIRMED BY:** | [ ]  YES [ ]  NO | **ID BAND CONFIRMED BY:** | [ ]  YES [ ]  NO |
| **MEDICAL RECORD SENT** | [ ]  YES, Electronically [ ]  NO (fill out appendix)[ ]  YES, Attached/Hard Copy | **MEDICAL RECORD RECEIVED** | [ ]  YES [ ]  NO |
| **BELONGINGS** | [ ]  WITH PATIENT | [ ]  LEFT IN ROOM [ ]  NONE | **BELONGINGS RECEIVED** | [ ]  YES [ ]  NO |
| **VALUABLES** | [ ]  WITH PATIENT | [ ]  LEFT IN SAFE [ ]  NONE | **VALUABLES RECEIVED** | [ ]  YES [ ]  NO |
| **MEDICATIONS***Attach medication list* | [ ] WITH PATIENT  | [ ]  LEFT ON UNIT [ ]  PHARMACY | **MEDICATIONS RECEIVED****Verify attached medication list** | [ ]  YES [ ]  NO |
| **PEDS / INFANTS** | **PEDS / INFANTS** |
| **APPROPRIATE BVM W/ TUBING & BULB SYRINGE**: SENT | [ ]  YES [ ] NO | **APPROPRIATE BVM W/ TUBING & BULB SYRINGE: RCVD** | [ ]  YES [ ]  NO |
| **OTHER EQUIPMENT SENT:** | [ ]  YES [ ] NO | **OTHER EQUIPMENT RECEIVED:** | [ ]  YES [ ]  NO |
| **14. Transferring to another Facility / Destination (name):** |
| Destination (address): | Point of Contact name/phone#: |
| **TIME TO STAGING AREA:** | **TIME LOADING COMPLETED:** |
| TRANSPORTATION [ ]  AMBULANCE. # AGENCY: [ ]  HELICOPTER [ ]  OTHER |
| ID BAND CONFIRMED [ ]  YES [ ]  NO BY | DEPARTURE TIME: |
| **TRANSFER CENTER & CONTACT #:** | **SENDING HOSPITAL FAX OR EMAIL CONFIRMATION SENT**: [ ]  YES [ ]  NO |
| **16. Prepared by** | PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: DATE/TIME: \_\_\_\_ FACILITY:  |