|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | | | | |