HICS 260 – PATIENT EVACUATION/TRANSFER TRACKING FORM

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:

- ☐ Hospital Bed
- ☐ Crib
- ☐ Isolette/Warmer
- ☐ Gurney
- ☐ Wheelchair
- ☐ Ambulatory
- ☐ Evacuation Device
- ☐ Other: _____

9. Accompanying Equipment (check those that apply below):

- ☐ 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

- ☐ Stable/No Injury/Non-EMS Transport/Discharge
- ☐ Stable/Low acuity/BLS Transport & Care
- ☐ Minimal/Moderate Acuity/ALS Transport & Care
- ☐ Moderate/Critical acuity/ALS 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:_____

HOSPITAL INCIDENT COMMAND SYSTEM

Purpose: Detail and account for patients transferred to another facility

Origination: Inpatient/Outpatient Unit Leader or Casualty Care Unit Leader

Place sending facility patient label