PATIENT EVACUATION TRACKING FORM

HOSPITAL INCIDENT COMMAND SYSTEM

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	☐ Other	☐ Other

Isolation ☐ Yes ☐ No Type

Reason

10. EVACUATING CLINICAL LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record sent ☐ Yes ☐ No

Addressograph sent ☐ Yes ☐ No

Belongings ☐ with patient ☐ left in room ☐ none

Valuables ☐ with patient ☐ left in safe ☐ none

Medications ☐ with patient ☐ left on unit ☐ to pharmacy

PEDS/INFANTS

Bag/Mask with tubing sent ☐ Yes ☐ No

Bulb Syringe sent ☐ Yes ☐ No

11. ARRIVING LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record received ☐ Yes ☐ No

Addressograph received ☐ Yes ☐ No

Belongings received ☐ Yes ☐ No

Valuables ☐ Yes ☐ No

Medications received ☐ Yes ☐ No

Bag/Mask with tubing received ☐ 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.