



**HICS 260N – PATIENT EVACUATION TRACKING FORM (SD County)**

<b>1. DATE</b>		<b>2. UNIT NICU</b>		<b>3. ATTENDING PHYSICIAN</b>			
<b>4. PATIENT NAME</b>		<b>5. MR #</b>		<b>6. BIRTH DATE</b>			
<b>7. DIAGNOSIS (ES)</b>				Place Patient Label / Bar Code Here			
<b>8. RESPIRATORY SUPPORT</b> <input type="checkbox"/> Oxygen FiO2 _____ % Liter Flow _____ L/minute <input type="checkbox"/> Continuous Positive Airway Pressure Level _____ cm H2O <input type="checkbox"/> Ventilator Type _____ <input type="checkbox"/> Ventilator Settings _____ <input type="checkbox"/> Chest Tube(s) # _____				<b>9. FAMILY NOTIFIED</b> <input type="checkbox"/> YES <input type="checkbox"/> NO CONTACT INFORMATION: _____			
<b>10. ACCOMPANYING EQUIPMENT/TUBES/LINES (CHECK THOSE THAT APPLY)</b>							
<b>Bed Type</b> <input type="checkbox"/> Isolette <input type="checkbox"/> Radiant Warmer <input type="checkbox"/> Bassinette <input type="checkbox"/> Crib Other _____  Bulb Syringe Sent <input type="checkbox"/> YES <input type="checkbox"/> NO Bag/Mask with Tubing Sent <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>Lines / IV's</b> <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Peripheral Arterial Line <input type="checkbox"/> Umbilical Artery Catheter <input type="checkbox"/> Umbilical Vein Catheter <input type="checkbox"/> Peripherally Inserted Central Catheter (PICC) <input type="checkbox"/> Surgically Placed Central Line Other _____		<b>Equipment</b> Monitoring <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Pulse oximetry (stand alone) Other _____ <input type="checkbox"/> IV Pumps <input type="checkbox"/> # Syringe _____ <input type="checkbox"/> # Volume Pump _____		<b>Nutrition</b> <input type="checkbox"/> NPO <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula _____ <input type="checkbox"/> NG/OG Feeding Tube <input type="checkbox"/> Gastrostomy Other _____	
ISOLATION <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE			
REASON							
<b>11. DEPARTING LOCATION</b>			<b>12. ARRIVING LOCATION</b>				
ROOM#		TIME		Facility			
ID Band Confirmed		By:		ID Band Confirmed			
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
Medical Record Sent <input type="checkbox"/> YES <input type="checkbox"/> NO			Accepting Physician				
Addressograph Sent <input type="checkbox"/> YES <input type="checkbox"/> NO			Admission Location: <input type="checkbox"/> NICU <input type="checkbox"/> ER <input type="checkbox"/> Ward <input type="checkbox"/> Other				
Belongings <input type="checkbox"/> with Patient <input type="checkbox"/> Left in Room <input type="checkbox"/> None		Place Triage Category Sticker Here Upon Evacuation					
Valuables <input type="checkbox"/> with Patient <input type="checkbox"/> Left in Safe <input type="checkbox"/> None							
Medications <input type="checkbox"/> with Patient <input type="checkbox"/> Left on Unit <input type="checkbox"/> to Pharmacy							
<b>13. TRANSFERRING TO ANOTHER FACILITY</b>							
TIME TO STAGING AREA			Time Referral Facility Contacted				
DESTINATION			TIME ARRIVAL TO RECEIVING FACILITY				
TRANSPORTATION <input type="checkbox"/> Ambulance Unit <input type="checkbox"/> Helicopter <input type="checkbox"/> Other:							
DEPARTURE TIME							
<b>13. TRANSFERRING FACILITY</b>							

**PURPOSE:** Document details and account for patients transferred to another facility. **ORIGINATION:** Medical Care Branch Director  
**ORIGINAL TO:** Patient **COPIES TO:** Patient Tracking Manager and Departing Location