



HICS 260 - PATIENT EVACUATION TRACKING FORM

1. Date		2. From (Unit)	
3. Patient Name		4. DOB	5. Medical Record Number
6. Diagnosis		7. Admitting Physician	
8. Family Notified <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: _____ CONTACT INFORMATION: _____			
9. Mode of Transport		10. Accompanying Equipment (check those that apply)	
<input type="checkbox"/> Hospital Bed <input type="checkbox"/> Gurney <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulatory <input type="checkbox"/> Other:		<input type="checkbox"/> IV Pump(s) <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Chest Tube(s) <input type="checkbox"/> Other: <input type="checkbox"/> Isolette/Warmer <input type="checkbox"/> Traction <input type="checkbox"/> Monitor <input type="checkbox"/> A-Line/Sw an <input type="checkbox"/> Other: <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Halo-Device <input type="checkbox"/> Cranial Bolt/Screw <input type="checkbox"/> Intraosseous Device <input type="checkbox"/> Other:	
11. Special Needs			
12. Isolation <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: _____ REASON: _____			
13. Evacuating Clinical Location		14. Arriving Location	
ROOM # _____ TIME _____		ROOM # _____ TIME _____	
ID BAND CONFIRMED BY:	<input type="checkbox"/> YES <input type="checkbox"/> NO	ID BAND CONFIRMED BY:	<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICAL RECORD SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL RECORD RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
BELONGINGS <input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE	BELONGINGS RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
VALUABLES <input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN SAFE <input type="checkbox"/> NONE	VALUABLES RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATIONS <input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT ON UNIT <input type="checkbox"/> PHARMACY	MEDICATIONS RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
PEDS / INFANTS		PEDS / INFANTS	
BAG/MASK WITH TUBING SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	BAG/MASK /W TUBING RCVD	<input type="checkbox"/> YES <input type="checkbox"/> NO
BULB SYRINGE SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	BULB SYRINGE RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Transferring to another Facility / Location			
TIME TO STAGING AREA _____		TIME DEPARTING TO RECEIVING FACILITY _____	
Destination			
TRANSPORTATION <input type="checkbox"/> AMBULANCE. # _____ AGENCY _____	<input type="checkbox"/> HELICOPTER <input type="checkbox"/> OTHER		
ID BAND CONFIRMED <input type="checkbox"/> YES <input type="checkbox"/> NO BY _____			
DEPARTURE TIME: _____			
16. Prepared by			
PRINT NAME: _____		SIGNATURE: _____	
DATE/TIME: _____		FACILITY: _____	



Purpose: Detail and account for patients transferred to another facility
Origination: Inpatient/Outpatient Unit Leader or Casualty Care Unit Leader
Copies to: Patient Tracking Manager, Medical Care Branch Director, evacuating clinical location, and Documentation Unit Leader

HICS 260 - PATIENT EVACUATION TRACKING FORM

- PURPOSE:** The HICS 260 - Patient Evacuation Tracking Form documents details and account for patients transferred to another facility.
- ORIGINATION:** Completed by the Operations Section as appropriate: the Inpatient Unit Leader, the Outpatient Unit Leader, or the Casualty Care Unit Leader, depending on where the identified patient is located.
- COPIES TO:** The original is kept with the patient through actual evacuation. Copies are distributed to the Patient Tracking Manager, the Medical Care Branch Director, the evacuating clinical location, and the Documentation Unit Leader.
- NOTES:** The information on this form may be used to complete HICS 255, Master Patient Evacuation Tracking Form. Additions or deletions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Date	Enter the date of the evacuation.
2	From	Enter the Unit the patient is leaving from.
3	Patient Name	Enter the patient's full name.
4	DOB	Enter the patient's date of birth (DOB).
5	Medical Record Number	Enter the patient's medical record number.
6	Diagnosis	Enter the primary diagnosis/diagnoses.
7	Admitting Physician	Enter the name of the patient's admitting physician.
8	Family Notified	Check yes or no; enter family contact information.
9	Mode of Transport	Identify mode of transportation needed.
10	Accompanying Equipment	Check appropriate boxes for any equipment being transferred with the patient.
11	Special Needs	Indicate if the patient has special needs, assistance, or requirements.
12	Isolation	Indicate if isolation is required, the type, and the reason.
13	Evacuating Clinical Location	Fill in information and check boxes to indicate originating room and what was sent with the patient (records, medications, and belongings).
14	Arriving Location	Fill in information and check boxes to indicate patient's arrival at the new location and whether materials sent with the patient were received.
15	Transferring to another Facility / Location	Document arrival and departure from the staging area, confirmation of ID band, and type of transportation used.
16	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.