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 ☐ YES ☐ NO NAME: _____ CONTACT INFORMATION: _____

9. Mode of Transport	10. Accompanying Equipment (check those that apply)		
☐ Hospital Bed	☐ IV Pump(s)	☐ Isolette/Warmer	☐ Foley Catheter
☐ Gurney	☐ Oxygen	☐ Traction	☐ Halo-Device
☐ Wheelchair	☐ Ventilator	☐ Monitor	☐ Cranial Bolt/Screw
☐ Ambulatory	☐ Chest Tube(s)	☐ A-Line/Swan	☐ Intraosseous Device
☐ Other:	☐ Other:	☐ Other:	☐ Other:

11. Special Needs

12. Isolation ☐ YES ☐ NO TYPE: _____ REASON: _____

13. Evacuating Clinical Location			14. Arriving Location	
ROOM # TIME			ROOM # TIME	
ID BAND CONFIRMED BY:		☐ YES ☐ NO	ID BAND CONFIRMED BY:	☐ YES ☐ NO
MEDICAL RECORD SENT		☐ YES ☐ NO	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	☐ WITH PATIENT	☐ LEFT ON UNIT ☐ PHARMACY	MEDICATIONS RECEIVED	☐ YES ☐ NO
PEDS / INFANTS			**PEDS / INFANTS**	
BAG/MASK WITH TUBING SENT		☐ YES ☐ NO	BAG/MASK /W TUBING RCVD	☐ YES ☐ NO
BULB SYRINGE SENT		☐ YES ☐ NO	BULB SYRINGE RECEIVED	☐ YES ☐ NO

15. Transferring to another Facility / Location

TIME TO STAGING AREA TIME DEPARTING TO RECEIVING FACILITY

Destination

TRANSPORTATION ☐ AMBULANCE. # AGENCY ☐ HELICOPTER ☐ OTHER

ID BAND CONFIRMED ☐ YES ☐ NO BY

DEPARTURE TIME:

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
Copies to: Patient Tracking Manager, Medical Care Branch Director, evacuating clinical location, and Documentation Unit Leader

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