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| 1. **DATE** |  | | | | | | | 1. **FACILITY NAME** | | | |  | | | | | | | | | | | |
| 1. **RESIDENT NAME** | | |  | | | | | | | | 1. **AGE** | |  | | | 1. **MEDICAL RECORD #** | | | |  | | | |
| 1. **SIGNIFICANT MEDICAL HISTORY** | | | |  | | | | | | | | | | | 1. **ATTENDING PHYSICIAN** | | | |  | | | | |
| 1. **FAMILY/GUARDIAN NOTIFIED** | | | | | YES  NO | | | | | **NAME/CONTACT INFORMATION** | | | | | | |  | | | | | | |
| 1. **TRANSPORTATION EQUIPMENT** | | | | | | | 1. **ACCOMPANYING EQUIPMENT** (CHECK THOSE THAT APPLY): | | | | | | | | | | | | | | | | |
| **HOSPITAL BED**  **GURNEY**  **WHEEL CHAIR**  **AMBULATORY**  **SPECIAL MATTRESS** | | | | | | | **IV PUMPS**  **OXYGEN**  **VENTILATOR**  **BLOOD GLUCOSE MONITOR**  **RESPIRATORY EQUIPMENT** | | | | | | **SERVICE ANIMAL**  **G TUBE PUMP**  **MONITOR**  **FOLEY CATHETER**  **OTHER** | | | | | | | | **List “OTHER” below:** | | |
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|  |  |  |
|  |  |  |
| 1. **SPECIAL NEEDS** | | |  | | | | | | | | | | | | | | | | | | | | |
| 1. **ISOLATION** | | YES  NO | | | | **TYPE:** | | |  | | | | | **REASON:** | | | |  | | | | | |

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| 1. **EVACUATING LOCATION** | | | | | | | | | | | |  | | 1. **ARRIVING LOCATION** | | | | | | | | | | | | | | | | |
| **ROOM#** | |  | | | | | **TIME** | |  | | |  | | **ROOM#** | | | | | |  | | | | | **TIME** | |  | | | |
| **ID BAND CONFIRMED** | | | | | YES  NO | | | | | | |  | | **ID BAND CONFIRMED** | | | | | | | | YES  NO | | | | | | | | |
| **BY** |  | | | | | | | | | | |  | | **BY** | | |  | | | | | | | | | | | | | |
| **MEDICAL RECORD SENT** | | | | | | | YES  NO | | | | |  | | **MEDICAL RECORD RECEIVED** | | | | | | | | | | | YES  NO | | | | | |
| **FACE SHEET**/**TRANSFER TAG SENT** | | | | | | | YES  NO | | | | |  | | **FACE SHEET**/**TRANSFER TAG RECEIVED** | | | | | | | | | | | YES  NO | | | | | |
| **BELONGINGS** | | | | | | WITH RESIDENT  LEFT IN ROOM  NONE | | | | | |  | | **BELONGINGS RECEIVED** | | | | | | | | | YES  NO | | | | | | | |
| **VALUABLES** | | | | | | WITH RESIDENT  LEFT IN ROOM  NONE | | | | | |  | | **VALUABLES RECEIVED** | | | | | | | | | YES  NO | | | | | | | |
| **MEDICATIONS** | | | | | | WITH RESIDENT  LEFT IN ROOM  NONE | | | | | |  | | **MEDICATIONS RECEIVED** | | | | | | | | | YES  NO | | | | | | | |
| 1. **TRANSFERRING TO ANOTHER FACILITY/ LOCATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TIME TO STAGING AREA** | | | | | |  | | | | | | | **TIME DEPARTING TO RECEIVING FACILITY** | | | | | | | | | | | | |  | | | |
| **DESTINATION** | | |  | | | | | | | | | | | | | | | **DEPATURE TIME:** | | | | | |  | | | | | |
| **MODE OF TRASNPORT** | | | | | **AMBULANCE UNIT**  **HELICOPTER**  **BUS**  **OTHER:** | | | | | | | | | | | | | | | | | | | | | | | | |
| **ID BAND CONFIRMED** | | | | | YES  NO | | | | | **ID BAND CONFIRMED BY** | | | | | | | | |  | | | | | | | | | | |
| 1. **PREPARED BY** | | | | **PRINT NAME:** | | | |  | | | | | | | | **SIGNATURE:** | | | | |  | | | | | | | |  |
| **DATE/TIME:** | | | |  | | | | | | | | **FACILITY:** | | | | |  | | | | | | | |  |
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**INSTRUCTIONS**

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| --- | --- | --- | --- |
| **PURPOSE:** | | Documents and accounts for residents transferred to another facility. | |
| **ORIGINATION:** | | Resident Services Branch Director, Operations Section Chief and/or IMT staff as appropriate | |
| **COPIES TO:** | | Planning Section Chief and the evacuating clinical location. Original is kept with the resident. | |
| **NOTES:** | | The information on this form may be used to complete NHICS 255, Master Resident 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** | **Facility Name** | | Enter the Facility Name the resident is leaving from. |
| **3** | **Resident Name** | | Enter the resident’s full name. |
| **4** | **Age** | | Enter the resident’s age. |
| **5** | **Medical Record #** | | Enter the resident’s medical record number. |
| **6** | **Significant Medical History** | | Enter significant medical history. |
| **7** | **Attending Physician** | | Enter the name of the resident’s attending physician. |
| **8** | **Family/Guardian Notified** | | Check yes or no; enter family/guardian contact information. |
| **9** | **Transportation Equipment** | | Identify type of transportation equipment (e.g., wheelchair, gurney) needed. |
| **10** | **Accompanying**  **Equipment** | | Check appropriate boxes for any equipment being transferred with the resident. |
| **11** | **Special Needs** | | Indicate if the resident has special needs, assistance, or requirements. |
| **12** | **Isolation** | | Indicate if isolation is required, the type, and the reason. |
| **13** | **Evacuating Location** | | Fill in information and check boxes to indicate originating room and what was sent with the resident (records, medications, and belongings). |
| **14** | **Arriving Location** | | Fill in information and check boxes to indicate resident’s arrival at new location and whether materials sent with the resident were received. |
| **15** | **Transferring to another Facility/ Location** | | Document arrival and departure from the staging area, confirmation of ID band, and mode 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. |