PATIENT EVACUATION TRACKING FORM – ACUTE CARE

(Barcode)
_____
(Ascending Patient Tracking #)

Place PATIENT Sticker Here (all 4 copies) or write in:
Patient Name: _____
MR #: _____ DOB: _____

Place FACILITY Sticker Here (all 4 copies) or write in:
Facility Name: _____
Phone: _____ Fax: _____

SENDING FACILITY: TO BE COMPLETED PRIOR TO PATIENT MOVEMENT FROM THE UNIT

PATIENT INFORMATION

A. **Face Sheet Attached**: Y / N B. **Room/Bed #**: _____ C. **Sex**: M / F D. **Weight**: _____ kg/lb (circle)
E. **Internal Holding Area Patient will be sent to**: ☐Bypass: Direct to Transport **OR** ☐Location: _____
Recommended Transport: ☐Ambulance (Paramedic) ☐Ambulance (EMT) ☐Wheelchair ☐Non-medical ☐Other:
G. **Family Notification**: Y / N Family Name: _____ Time: _____ Cell#: _____ Ph#: _____
Legal Guardian Notification: Y / N Guardian Name: _____ Time: _____ Cell#: _____ Ph#: _____
Sending MD: _____ Ph#: _____ Time: _____
PMD Notification: Y / N PMD Name: _____ Time: _____ Ph#: _____
H. **Interpreter**: Y / N Language: _____ I. **Sign Language**: Y / N

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GENERAL

A. **Code Status**: ☐Full Code ☐No Code ☐DNR ☐DNI ☐CMO (Attach Orders) ☐Advance Directives: Is Document Present Y / N
B. **Allergies**: _____
C. **Primary Dx**: _____ Secondary Dx: _____

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CRITICAL MEDICAL DATA

A. **Precautions**: ☐Suicidal ☐Contact ☐Airborne ☐Droplet Reason: _____
B. **Diabetic**: Y / N Last Meal: _____ Insulin: Y / N Last finger stick time & value (standard value): _____
C. **Immunocompromised**: Y / N D. **Level of Consciousness**: _____
_____
E. **Vision Intact**: Y / N F. **Hearing Intact**: Y / N G. **Language Barrier**: Y / N
H. **Last Vital Signs Stable**: Y / N If NO – Document: _____
I. ☐CHF ☐CAD (unstable) ☐Chronic Lung Disease ☐Full Anticoagulation ☐Post-op Patient ☐Acute Alcohol Withdrawal ☐Open Wound **Attach recent imaging / lab studies, if possible**

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EQUIPMENT

A. **Lines/Tubes/Drains**: ☐Chest ☐PEG ☐NGT ☐IV - Central/Peripheral (circle) ☐Ostomy - Urine/Colon (circle) ☐Foley ☐Wound Drain ☐Other: _____
B. **Vent/C-PAP/Bi-PAP**: Y / N Document: _____
C. **Wound**: Y / N Location: _____
D. **Special Bed**: Y / N Type: _____ E. ☐**Oxygen** F. ☐**Suction**: Freq/Type of Secretion: _____
E. **Dialysis:** Y / N Last Dialysis (Date/Time): _____

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SAFETY / BEHAVIORAL / RESTRAINTS

A. **Seizure**: Y / N B. **Aspiration**: Y / N C. **Fall Risk**: Y / N
D. **Restraints**: ☐Behavioral ☐Medical Time Started: _____
E. **Behavior Concerns**: Y / N List: _____ Duty to Warn – Completed: Y / N
F. **Transfers**: Dependence - ☐Independent ☐Supervision ☐Partial Assist: 1 / 2 person

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CRITICAL MEDS

CRITICAL MEDS – MAR Attached: Y / N (if not attached, include medication, dose, route & last dosage):
_____
_____
This Portion of Form Completed By (Printed Name/Signature/Phone/Date):

SENDING FACILITY: TO BE COMPLETED AT TIME OF ARRIVAL INTO AND UPON DEPARTURE FROM HOLDING AREA

HOLDING AREA

A. **Holding Area Location**: _____ Time Arrived: _____ Received by (Name): _____
B. **Time Departed**: _____ Destination Facility: _____
C. **Vehicle ID** (Company Name, Vehicle#, State): _____
Accompanied by (staff/family member name): _____
D. **Patient ID Band/Nametag Confirmed**: Y / N / n/a
E. **Equipment Sent with Patient**: ☐C-PAP/BiPAP: _____ ☐Dialysis Machine ☐External Pacemaker ☐Isolette/Warmer ☐IV Pumps: _____ ☐Monitor ☐NEO puff ☐Pulse Oximeter ☐Syringe Pump: _____ ☐Ventilator: _____ ☐Other: _____
F. **Items Sent with Patient***: ☐DVD-Radiographs ☐Personal Belongings (☐with patient / ☐left on unit / ☐none) ☐Medical Record ☐Medications ☐Valuables (☐with patient / ☐left on unit / ☐none) ☐Other: _____
This Portion of Form Completed By (Printed Name/Signature/Phone/Date):

RECEIVING FACILITY: TO BE COMPLETED AT TIME OF ARRIVAL AT RECEIVING FACILITY

RECEIVING

A. **Time/Date Arrived**: _____ Facility Name: _____ Received by (Name): _____
Initial Care Location: _____ Patient ID Band/Nametag Confirmed: Y / N
B. **Receiving Facility MR#:** _____ **New Patient Tracking #:** _____
C. **Confirmed Receipt of Patient**: ☐with Sending Facility **OR** ☐with Regional Call Center
D. **Equipment Received with Patient** (verify against list for HOLDING AREA and note changes): _____
_____
E. **Items Received with Patient** (verify against list for HOLDING AREA and note changes): _____
_____
This Portion of Form Completed By (Printed Name/Signature/Phone/Date):

Copy 1 – Copy 1 –1) If active, Regional Call Center 2) Health & Medical Area Command (if other areas are not operational)
Copy 2 – To be retained by Receiving Facility
Copy 3 – To be retained by Sending Facility
COPY 1