# PATIENT EVACUATION TRACKING FORM

HOSPITAL INCIDENT COMMAND SYSTEM

1. DATE

2. UNIT

3. PATIENT NAME

4. AGE

5. MR#

6. DIAGNOSIS(-ES)

7. ADMITTING PHYSICIAN

8. FAMILY NOTIFIED

☐ Yes ☐ No Contact Information:

9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)

| | | | |
|---|---|---|---|
| ☐ Hospital Bed | ☐ IV Pump(s) | ☐ Isolette/Warmer | ☐ Foley Catheter |
| ☐ Gurney | ☐ Oxygen | ☐ Traction | ☐ Halo-Device |
| ☐ Wheel Chair | ☐ Ventilator | ☐ Monitor | ☐ Cranial Bolt/Screw |
| ☐ Ambulatory | ☐ Chest Tube(s) | ☐ A-Line/Swan | ☐ IO Device |
| ☐ Other | ☐ Other | ☐ Other | ☐ Other |

Isolation ☐ Yes ☐ No Type

Reason

10. EVACUATING CLINICAL LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record sent ☐ Yes ☐ No

Addressograph sent ☐ Yes ☐ No

Belongings ☐ with patient ☐ left in room ☐ none

Valuables ☐ with patient ☐ left in safe ☐ none

Medications ☐ with patient ☐ left on unit ☐ to pharmacy

PEDS/INFANTS

Bag/Mask with tubing sent ☐ Yes ☐ No

Bulb Syringe sent ☐ Yes ☐ No

11. ARRIVING LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record received ☐ Yes ☐ No

Addressograph received ☐ Yes ☐ No

Belongings received ☐ Yes ☐ No

Valuables ☐ Yes ☐ No

Medications received ☐ Yes ☐ No

Bag/Mask with tubing received ☐ Yes ☐ No

Bulb Syringe received ☐ Yes ☐ No

12. TRANSFERRING TO ANOTHER FACILITY

Time to Staging Area

Time Departing to Receiving Facility

Destination

Transportation ☐ Ambulance unit ☐ Helicopter ☐ Other:

ID Band Confirmed ☐ Yes ☐ No By:

Departure Time

13. FACILITY NAME

**PURPOSE**: DOCUMENT DETAILS AND ACCOUNT FOR PATIENTS TRANSFERRED TO ANOTHER FACILITY.
**ORIGINATION**: INPATIENT UNIT LEADER, OUTPATIENT UNIT LEADER AND/OR CASUALTY CARE UNIT LEADER. **ORIGINAL TO**: PATIENT.
**COPIES TO**: PATIENT TRACKING MANAGER, MEDICAL CARE BRANCH DIRECTOR AND EVACUATING CLINICAL LOCATION.