

# HICS 260 - PATIENT EVACUATION TRACKING FORM

<b>1. Date</b> 19-DEC-2019		<b>2. From (Unit)</b> ICU	
<b>3. Patient Name</b> Stanley W. Blue		<b>4. DOB</b> 11-March-1969	<b>5. Medical Record Number</b> 12345678910
<b>6. Diagnosis</b> Epidural Bleed		<b>7. Admitting Physician</b> Dr. Rocket-scientist	
<b>8. Family Notified</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO    NAME: Shirley Blue    CONTACT INFORMATION: (123) 123-1234			
<b>9. Mode of Transport</b>		<b>10. Accompanying Equipment</b> (check those that apply)	
<input type="checkbox"/> Hospital Bed <input checked="" type="checkbox"/> Gurney <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulatory <input type="checkbox"/> Other:		<input checked="" type="checkbox"/> IV Pump(s) <input checked="" type="checkbox"/> Oxygen <input checked="" 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/Swan <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:	
<b>11. Special Needs</b> Ventilator			
<b>12. Isolation</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    TYPE: _____    REASON: _____			
<b>13. Evacuating Clinical Location</b>		<b>14. Arriving Location</b>	
ROOM # ICU 3                      TIME 1600		ROOM # ICU 11                      TIME 1715	
ID BAND CONFIRMED BY: HELEN KELLER		ID BAND CONFIRMED BY: TINA TURNER	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
MEDICAL RECORD SENT		MEDICAL RECORD RECEIVED	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
BELONGINGS	<input checked="" type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE	BELONGINGS RECEIVED
			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
VALUABLES	<input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN SAFE <input checked="" type="checkbox"/> NONE	VALUABLES RECEIVED
			<input type="checkbox"/> YES <input type="checkbox"/> NO NA
MEDICATIONS	<input type="checkbox"/> WITH PATIENT	<input checked="" type="checkbox"/> LEFT ON UNIT <input type="checkbox"/> PHARMACY	MEDICATIONS RECEIVED
			<input type="checkbox"/> YES <input type="checkbox"/> NO NA
<b>PEDS / INFANTS</b>		<b>PEDS / INFANTS</b>	
BAG/MASK WITH TUBING SENT		BAG/MASK /W TUBING RCVD	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
BULB SYRINGE SENT		BULB SYRINGE RECEIVED	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>15. Transferring to another Facility / Location</b>			
TIME TO STAGING AREA    1605		TIME DEPARTING TO RECEIVING FACILITY 1615	
<b>Destination</b>			
TRANSPORTATION <input checked="" type="checkbox"/> AMBULANCE. # 68    AGENCY    Sunshine Ambulance		<input type="checkbox"/> HELICOPTER <input type="checkbox"/>	
OTHER			
ID BAND CONFIRMED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO    BY INDIANA JONES			
DEPARTURE TIME: 1615			
<b>16. Prepared by</b>			
PRINT NAME: Lone Ranger		SIGNATURE: <i>Lone Ranger</i>	
DATE/TIME: 19-DEC-2019 1615		FACILITY: St. Elsewhere	



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