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

Print Reset Send Save

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