Resident Evacuation Critical Information and Tracking Form

	Receiving Facility	Movement Times	Place patient identity label or imprint or write here.
__	_____	At Holding ___:___ ___	Name (last)_____(first) _____
__	_____	At Loading ___:___ ___	Age _____ Gender [ ] Male [ ] Female DOB: ____/____/_____
__	_____	Left Facility ___:___ __	Primary Physician _____Room or Bed #_____
__	_____	Arrived Dest. ___:___ _	
__	_____		
__	_____		

Resident Mobility Level Transportation Assistance Level			Minimum Staff to Loading Area			Transport Vehicle		Trans port Agency: _____ Unit/Vehicle # _____ Equipment / Items to Accompany Resident
			clinical	Non-clinical				
TAL		***BEHAVIORAL HEALTH***						Oxygen
TAL 1		***NON- AMBULATORY***	1	1		BLS Ambulance		Suction
			2	2		ALS Ambulance		Infusion Pump
								Medications
TAL 2		***WHEELCHAIR***	0	1		Wheelchair Van / Ambulette		Critical Supplies
								Medical Records
								Other
TAL 3		***AMBULATORY***	0	1:5		Transit/ School Bus		Other
								Other
						Other Specify		Other
ISOLATION STATUS				Contact		Droplet		Airborne

Advanced Directives	Name/Contact #		Interpreter Needed?		ASL		Language:
DNR	DNI		Health Care Proxy		Living Will	MOLST	Copy Enclosed
ALLERGIES	None		Latex		Other:		
MENTAL STATUS	Oriented		Alert		Lethargic	Mildly Confused	Severely Confused
Behavior Problems / Safety Risk	None		Wanders		Elopement Risk	Verbally Abusive	Physically Abusive
Fall Risk	None		Low		High		
Restraint	Vest / Posey		Wrist/ Mitt		4 Point	Other	Date/ time Applied
Special Requirements	Oxygen (mask) /pm		Oxygen (cannulae)/pm		Suction	Seizure Precautions	
Transfers	Independent		Supervision		Partial Assist 1	Partial Assist 2	Total Assist

Activities of Daily Living									
Independent		Supervision		Partial Assist		Total Assist			
Continent		Incontinent Bowl		Incontinent Bladder		Other:			
Diet		Special	**Consistency**		Aspiration Precautions				
NPO		Regular:		Regular		Ground		Thickened		Pureed		Liquid

Personal Assistive Devices With Resident											
None		Cane		Walker		Personal Wheelchair		Glasses			
Dentures		Hearing Aid		Prosthesis Type:		Other:					

Notifications (name/date/time)	Family:	Private MD:

Last Action Prior to Departure			Document time and findings	
Last Temperature:	Last Heart Rate:	Last Blood Pressure:	Last Accu-Check:	Last Breath Sounds:
Last Medication Given(name/dose/route/time):			Last Meal (food/date/time):	

Next Medication / Intervention Needed					None Until:		
Name	**Day/ Time Needed**	**Administered?**			**By**	**Date**	**Time**
		Yes		**No**			
		Yes		**No**			
		Yes		**No**			

Notes During Transit	Document all care given or status updates Use other side if needed
Time	**Note**

Receiving Facility to confirm receipt of the resident by faxing a copy of this form to: _____