

RESIDENT/MEDICAL RECORD/STAFF/EQUIPMENT TRACKING SHEET

THIS PORTION TO BE COMPLETED BY EVACUATING/SENDING FACILITY

Sending Facility: _____
 Contact Person: _____
 Tel (____) _____ Fax (____) _____

Receiving Facility: _____
 Contact Person: _____
 Tel (____) _____ Date/Time Called: _____

Resident	Contact Information <i>(Note Date & Time Contacted)</i>	Sent with Resident <i>(Check all that apply)</i>	EMS or Bus Company <i>Name & Vehicle ID</i>	Time Vehicle <i>Departed</i>	Time <i>Arrived/Left Stop Over Point</i>	Time/Date <i>Arrived</i> RECEIVING FACILITY TO COMPLETE
Name: _____ MR or Tracking # _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: __/__/____	Family Contact: _____ Tel (____) _____ Date/Time: _____ Physician: _____ Tel (____) _____ Date/Time: _____	<input type="checkbox"/> Chart <input type="checkbox"/> Meds <input type="checkbox"/> MAR <input type="checkbox"/> Equipment: _____ <input type="checkbox"/> Staff (Name): _____			A: L:	
Name: _____ MR or Tracking # _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: __/__/____	Family Contact: _____ Tel (____) _____ Date/Time: _____ Physician: _____ Tel (____) _____ Date/Time: _____	<input type="checkbox"/> Chart <input type="checkbox"/> Meds <input type="checkbox"/> MAR <input type="checkbox"/> Equipment: _____ <input type="checkbox"/> Staff (Name): _____			A: L:	
Name: _____ MR or Tracking # _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: __/__/____	Family Contact: _____ Tel (____) _____ Date/Time: _____ Physician: _____ Tel (____) _____ Date/Time: _____	<input type="checkbox"/> Chart <input type="checkbox"/> Meds <input type="checkbox"/> MAR <input type="checkbox"/> Equipment: _____ <input type="checkbox"/> Staff (Name): _____			A: L:	
Name: _____ MR or Tracking # _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: __/__/____	Family Contact: _____ Tel (____) _____ Date/Time: _____ Physician: _____ Tel (____) _____ Date/Time: _____	<input type="checkbox"/> Chart <input type="checkbox"/> Meds <input type="checkbox"/> MAR <input type="checkbox"/> Equipment: _____ <input type="checkbox"/> Staff (Name): _____			A: L:	
Name: _____ MR or Tracking # _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: __/__/____	Family Contact: _____ Tel (____) _____ Date/Time: _____ Physician: _____ Tel (____) _____ Date/Time: _____	<input type="checkbox"/> Chart <input type="checkbox"/> Meds <input type="checkbox"/> MAR <input type="checkbox"/> Equipment: _____ <input type="checkbox"/> Staff (Name): _____			A: L:	

Special Notes: _____

THIS PORTION TO BE COMPLETED BY RECEIVING FACILITY

INSTRUCTIONS: COMPLETE THIS BOX, THE FINAL COLUMN ABOVE, AND THE INFLUX OF RESIDENTS LOG.

Receiving Facility Name: _____ City: _____ State: _____
 Person Completing Form: _____ Time Completed: _____
 Did you communicate receipt of resident with the LTC Coordinating Center or Disaster Struck (Sending) Facility? Yes No (if no, please do so now)
 Print Name of Primary Contact: _____ Phone: _____ Fax: _____