RESIDENT EMERGENCY EVACUATION FORM

(Barcode Label/Triage Tag – All 3 Copies)

_____

Triage Tag Number

Sending Facility: _____

Address: _____

Contact Name: _____ Title: _____

Tel (_____) _____

Receiving Facility: _____

Address: _____

Confirmed Sending with:

Name: _____ Title: _____

Tel (_____) _____ Date/Time Called: _____

Transport Via: ☐ ALS ☐ BLS ☐ Wheelchair Van ☐ Bus/Van

Resident Name *(last, first, middle init)*: ☐ Photo

_____

DOB: ____/____/_____ Sex: ☐ M ☐ F

Language: ☐ English ☐ Other _____

Alternate Communication: _____

Date Admitted (*most recent*): / /

Contact Person: _____

Relationship (*check all that apply*)

☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other

Tel (_____) _____

Notified of transfer? ☐ Yes ☐ No

Aware of clinical situation? ☐ Yes ☐ No

Primary Care Clinician in Nursing Home / Pharmacy

☐ MD ☐ NP ☐ PA

Name: _____

Tel (_____) _____

Facility Pharmacy: _____

Tel (_____) _____

Critical Diagnosis: _____ Treatments: _____

Code Status: ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain ☐ Other (attach advanced directives or DNR)

MEDICATIONS ☐ MAR Attached

DRUG, STRENGTH, MODE	FREQUENCY	LAST GIVEN	DRUG, STRENGTH, MODE	FREQUENCY	LAST GIVEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Key Clinical Information:

Relevant diagnoses: ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ CA: _____ ☐ Other: _____

Vital Signs: BP: _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____ Time taken (*am/pm*): _____

Most recent pain level: _____ (☐ N/A) Pain location: _____

Most recent pain med: _____ Date given: _____/_____/_____ Time: (*am/pm*): _____

Usual Mental Status: ☐ Dementia

☐ Alert, oriented, follows instructions

☐ Alert, disoriented, but can follow simple instructions

☐ Alert, disoriented, cannot follow simple instructions

☐ Not Alert

Behavior Problems / Safety Risk: ☐ None

☐ Elopement

☐ Verbally Aggressive

☐ Physically Aggressive / Harm to self or others

☐ 1:1 Supervision (Consider evac to Hospital)

Isolation Precautions: ☐ None

☐ MRSA ☐ VRE Site: _____

☐ C.difficile ☐ Norovirus

☐ Respiratory virus or flu ☐ Private Room Required

☐ Other: _____

Devices and Treatments:

☐ O2 Rate: _____ L/min ☐ Nasal Cannula ☐ Mask (☐ Chronic ☐ New)

☐ Maintain O2 Sat. above: _____ ☐ Nebulizer therapy (☐ Chronic ☐ New)

☐ CPAP Settings: _____ ☐ BiPAP settings: _____

☐ Pacemaker ☐ IV (Access Type: _____) ☐ PICC line

☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator

☐ Ostomy ☐ Speaking Valve ☐ Dialysis: ☐ HEMO ☐ Peritoneal

☐ Trach size: _____ Sx: _____ Frequency: _____

☐ Vent Settings: _____ ☐ Other: _____

Risk Alerts:

☐ Allergies (*food/meds*): _____

☐ Anticoagulation ☐ Falls ☐ Seizures ☐ Limited / non-weight bearing (☐ L ☐ R)

☐ Swallowing / Aspiration precautions ☐ Needs meds crushed

☐ Skin / wound care: _____ ☐ Needs special mattress

☐ Pressure ulcers (stage, location, appearance, treatment):

_____

☐ Other: _____

DIET: ☐ Regular Diet

☐ Diabetic: Last Insulin _____ Last Meal _____

☐ Religious Restrictions: _____

☐ Thickened Liquids Consistency: _____

☐ NPO ☐ Modified Diet _____ ☐ Meal Assist

☐ Enteral Feeding or TPN Type _____ Rate _____ Daily amount: _____

Other: _____

ADLs (I = Independent D = Dependent A = Needs Assistance)

	I	D	A
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐

Incontinence:

☐ Bladder ☐ Bowel

☐ Can ambulate independently

☐ Assistive device: _____

☐ Needs human assistance to ambulate

Transfers: ☐ Independent ☐ Needs supervision

☐ Partial assist ☐ Total assist

☐ Visually Imp / Blind ☐ Service Animal ☐ Deaf

Attachments:

☐ Face Sheet ☐ MAR ☐ TAR (treatments) ☐ POS (doctor's orders) ☐ Pertinent Labs

☐ Surgical Reports ☐ Copy of Signed DNR Order ☐ Original DNR ☐ Advance Directives

☐ Skin Guide ☐ Other: _____ ☐ X-rays, EKGs, scans

Personal Belongings Sent With Resident:

☐ Eyeglasses ☐ Contact Lenses ☐ Hearing Aid: L / R

☐ Dentures: U / L ☐ Jewelry ☐ Other: _____

Form Completed By (*name/title*): _____ **Signature:** _____

Report Called in By (*name/title*): _____

Report Called in To (*name/title*): _____ Date: ____/____/_____ Time (*am/pm*): _____

Additional Relevant Information:

_____

_____

_____

_____

Top Copy – Receiving Facility **Middle Copy – EMS / Transportation** **Bottom Copy – Disaster Struck Facility**