INFLUX OF RESIDENTS LOG

RECEIVING FACILITY INSTRUCTIONS: COMPLETE AND MATCH AGAINST RESIDENT/MEDICAL RECORD/STAFF/EQUIPMENT TRACKING SHEET

Resident	*Sending Facility (Facility Received From)*	*Contact Information (Note Date & Time Contacted)*	*Received with Resident (Check all that apply)*	*Time/Date Arrived*	*Time Left Triage (T) / Destination (D)*
Name: ____________ MR or Tracking # ____________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ____________ Tel (____) ____________ Date/Time: ____________ *Physician*: ____________ Tel (____) ____________ Date/Time: ____________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ____________ ____________ ____________ ☐ Staff (Name):____________ ____________		T: D:
Name: ____________ MR or Tracking # ____________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ____________ Tel (____) ____________ Date/Time: ____________ *Physician*: ____________ Tel (____) ____________ Date/Time: ____________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ____________ ____________ ____________ ☐ Staff (Name):____________ ____________		T: D:
Name: ____________ MR or Tracking # ____________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ____________ Tel (____) ____________ Date/Time: ____________ *Physician*: ____________ Tel (____) ____________ Date/Time: ____________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ____________ ____________ ____________ ☐ Staff (Name):____________ ____________		T: D:
Name: ____________ MR or Tracking # ____________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ____________ Tel (____) ____________ Date/Time: ____________ *Physician*: ____________ Tel (____) ____________ Date/Time: ____________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ____________ ____________ ____________ ☐ Staff (Name):____________ ____________		T: D:
Name: ____________ MR or Tracking # ____________ Sex: ☐ M ☐ F DOB: ____/____/_______		*Family Contact*: ____________ Tel (____) ____________ Date/Time: ____________ *Physician*: ____________ Tel (____) ____________ Date/Time: ____________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ____________ ____________ ____________ ☐ Staff (Name):____________ ____________		T: D:

Special Notes: ____

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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:

Top Copy – Fax to Sending Facility **Middle Copy – EMS / Transportation** **Bottom Copy – Retain** **Fax Copy to LTC Coordinating Center**