

# 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: \_\_\_\_\_  Blood Type: \_\_\_\_\_  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)

- |                                  |                          |                          |                          |                          |                          |                          |                          |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bathing                          | <input type="checkbox"/> | I                        | <input type="checkbox"/> | D                        | <input type="checkbox"/> | A                        | <input type="checkbox"/> |
| Dressing                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Toileting                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Incontinence:                    |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bowel   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 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: