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 (Note Date & Time Contacted)*	*Sent with Resident (Check all that apply)*	*Transport Company Name, Vehicle ID, Driver Name and Cell Phone #*	*Time Vehicle Departed*	*Time Arrived/Left Stop Over Point*	*Time/Date Arrived* **RECEIVING FACILITY TO COMPLETE**
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ___/___/_____	*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ☐ Staff (Name):________ ________			A: L:	
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ___/___/_____	*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ☐ Staff (Name):________ ________			A: L:	
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ___/___/_____	*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ☐ Staff (Name):________ ________			A: L:	
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ___/___/_____	*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ☐ Staff (Name):________ ________			A: L:	
Name: ________ MR or Tracking # ________ Sex: ☐ M ☐ F DOB: ___/___/_____	*Family Contact*: ________ Tel (____) ________ Date/Time: ________ *Physician*: ________ Tel (____) ________ Date/Time: ________	☐ Chart ☐ Meds ☐ MAR ☐ Equipment: ________ ________ ☐ Staff (Name):________ ________			A: L:	

Special Notes: ____
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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: __________

Top Copy – Receiving Facility **Middle Copy – EMS / Transportation** **Bottom Copy – Disaster Struck Facility** **Fax Copy to LTC Coordinating Center**