

INFLUX ***** MassMAP – INFLUX OF RESIDENTS LOG

MR# or Tracking #	Facility Received From	Resident Name (Last, First)	Sex	DOB	Arrival Time	Equip. Received (detail)	What was received with Resident	Family Contact: Date (D), Time (T), Name (N), Phone # (P)	Physician Contact: Date (D), Time (T), Name (N), Phone # (P)	Time Left Triage/ Destination (Disposition)
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	
						Y / N	Chart Y N Meds Y N MAR Y N	D: T: N: P:	D: T: N: P:	

Special Notes: _____ Page ____ of ____

Receiving Facility Actions – Please complete:
Match against Resident/MR/Staff/Equip. Sheet

Facility Name: _____ City: _____ State: _____

A) Did you communicate receipt of residents with the LTC Coordinating Center/RMCC or Disaster Struck Facility? YES / NO (if no, please do so now)

B) Print Name of Key Contact: _____ Phone #: _____ Fax #: _____