HICS 260 – PATIENT TRACKING FORM (For Transfers and Discharges)

1. DATE	**2. UNIT**	
3. PATIENT NAME	**4. AGE**	**5. MR #**
6. DIAGNOSIS (-ES)	**7. ADMITTING PHYSICIAN**	

8. FAMILY NOTIFIED

☐ YES ☐ NO CONTACT INFORMATION:

9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY

☐ Hospital Bed	☐ IV Pumps	☐ Isolette/Warmer	☐ Foley Catheter
☐ Gurney	☐ Oxygen	☐ Traction	☐ Halo-Device
☐ Wheel Chair	☐ Ventilator	☐ Monitor	☐ Cranial Bolt/Screw
☐ Ambulatory	☐ Chest Tube(s)	☐ A-Line/Swan	☐ IO Device
☐ Other	☐ Other	☐ Other	☐ Other

ISOLATION ☐ YES ☐ NO TYPE

REASON

10. DEPARTING LOCATION		**11. ARRIVING LOCATION**	
ROOM#	TIME	ROOM #	TIME
ID Band Confirmed ☐ YES ☐ NO	By:	ID Band Confirmed ☐ YES ☐ NO	By:
Medical Record Sent ☐ YES ☐ NO		Medical Record Sent ☐ YES ☐ NO	
Belongings ☐ with Patient ☐ Given to family ☐ None		Belongings Received ☐ YES ☐ NO	
Valuables ☐ with Patient ☐ Left in Safe ☐ None		Valuables ☐ YES ☐ NO	
Medications ☐ with Patient ☐ Given to family ☐ other Explain other:		Medications Received ☐ YES ☐ NO	
PEDS/INFANTS			
Bag/Mask with Tubing Sent ☐ YES ☐ NO		Bag/Mask with Tubing Received ☐ YES ☐ NO	
Bulb Syringe Sent ☐ YES ☐ NO		Bulb Syringe Received ☐ YES ☐ NO	

12. TRANSFERRING TO ANOTHER FACILITY

TIME TO STAGING AREA	TIME DEPARTING TO RECEIVING FACILITY

DESTINATION

TRANSPORTATION ☐ Ambulance Unit ☐Helicopter ☐ Other:

ID BAND CONFIRMED ☐ YES ☐ NO BY: (please print)

DEPARTURE TIME

13. FACILITY NAME