

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			
<input type="checkbox"/> YES <input type="checkbox"/> NO CONTACT INFORMATION:			
9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)			
<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> IV Pumps	<input type="checkbox"/> Isolette/Warmer	<input type="checkbox"/> Foley Catheter
<input type="checkbox"/> Gurney	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Traction	<input type="checkbox"/> Halo-Device
<input type="checkbox"/> Wheel Chair	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Monitor	<input type="checkbox"/> Cranial Bolt/Screw
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Chest Tube(s)	<input type="checkbox"/> A-Line/Swan	<input type="checkbox"/> IO Device
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
ISOLATION <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE	
REASON			
10. DEPARTING LOCATION		11. ARRIVING LOCATION	
ROOM#	TIME	ROOM #	TIME
ID Band Confirmed <input type="checkbox"/> YES <input type="checkbox"/> NO	By:	ID Band Confirmed <input type="checkbox"/> YES <input type="checkbox"/> NO	By:
Medical Record Sent <input type="checkbox"/> YES <input type="checkbox"/> NO		Medical Record Sent <input type="checkbox"/> YES <input type="checkbox"/> NO	
Belongings <input type="checkbox"/> with Patient <input type="checkbox"/> Given to family <input type="checkbox"/> None		Belongings Received <input type="checkbox"/> YES <input type="checkbox"/> NO	
Valuables <input type="checkbox"/> with Patient <input type="checkbox"/> Left in Safe <input type="checkbox"/> None		Valuables <input type="checkbox"/> YES <input type="checkbox"/> NO	
Medications <input type="checkbox"/> with Patient <input type="checkbox"/> Given to family <input type="checkbox"/> other Explain other:		Medications Received <input type="checkbox"/> YES <input type="checkbox"/> NO	
PEDS/INFANTS			
Bag/Mask with Tubing Sent <input type="checkbox"/> YES <input type="checkbox"/> NO		Bag/Mask with Tubing Received <input type="checkbox"/> YES <input type="checkbox"/> NO	
Bulb Syringe Sent <input type="checkbox"/> YES <input type="checkbox"/> NO		Bulb Syringe Received <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. TRANSFERRING TO ANOTHER FACILITY			
TIME TO STAGING AREA		TIME DEPARTING TO RECEIVING FACILITY	
DESTINATION			
TRANSPORTATION <input type="checkbox"/> Ambulance Unit <input type="checkbox"/> Helicopter <input type="checkbox"/> Other:			
ID BAND CONFIRMED <input type="checkbox"/> YES <input type="checkbox"/> NO BY: (please print)			
DEPARTURE TIME			
13. FACILITY NAME			