

Patient Critical Evacuation Information Tracking Form

NOTE: After completion of form please make **THREE** copies: **ONE** for sending facility, **ONE** for EMS, and **ONE** for receiving facility.

Sending Facility: _____

Receiving Facility: _____

Patient Name: (PRINT) _____

Date of Birth: ____/____/____ **Sex:** Male Female

Transferring Facility Medical Record Number: _____

Method of Transport: Ambulatory Wheelchair Basic Life Support Advanced Life Support

Emergency Contact: _____ **Telephone #** _____

Notified of Transfer : YES NO

Attending Physician: _____ **Notified of Transfer:** YES NO

Primary Diagnosis: _____

Do Not Resuscitate: YES (attach copy) NO **Advanced Directives:** YES (attach copy) NO

Healthcare Proxy: YES (attach copy) NO

Date transferred: _____ **Time of arrival at receiving facility:** _____

Equipment owned by sending facility accompanying patient during transport:

_____	_____
_____	_____
_____	_____
_____	_____

COMMENTS: _____

