NHICS

NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 255 | MASTER RESIDENT EVACUATION TRACKING FORM

1. INCIDENT NAME:		**2. FACILITY NAME:**	
3. DATE PREPARED:		**4. RESIDENT TRACKING MANAGER:**	

5. RESIDENT EVACUATION INFORMATION

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED** (TIME/TRANSPORT CO.)	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED** (TIME/TRANSPORT CO.)	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

	RESIDENT NAME:				**MEDICAL RECORD #:**	
DISPOSITION	**MODE OF TRANSPORTATION**	**ACCEPTING FACILITY NAME & CONTACT INFO**	**TIME FACILITY CONTACTED & REPORT GIVEN**	**TRANSFER INITIATED** (TIME/TRANSPORT CO.)	**MED RECORD SENT:**	☐ YES ☐ NO
					MEDICATION SENT:	☐ YES ☐ NO
☐ HOME ☐ FACILITY TRANSFER ☐ TEMP. SHELTER					**MD/FAMILY NOTIFIED:**	☐ YES ☐ NO
					ARRIVAL CONFIRMED:	☐ YES ☐ NO

6. CERTIFYING OFFICER:		**7. DATE/TIME SUBMITTED:**	

PURPOSE: RECORD INFORMATION CONCERNING RESIDENT DISPOSITION DURING A FACILITY EVACUATION
ORIGINATION: OPERATIONS BRANCH
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER LEADER