NHICS
NURSING HOME INCIDENT COMMAND SYSTEM

NHICS FORM 260 | INDIVIDUAL RESIDENT EVACUATION TRACKING FORM

1. FACILITY NAME:		**2. DATE:**	
3. UNIT:			
4. RESIDENT NAME:		**5. AGE:**	
6. MEDICAL RECORD #:		**7. SIGNIFICANT MEDICAL HISTORY:**	
8. ATTENDING PHYSICIAN:			
9. FACILITY NOTIFIED:	☐ YES ☐ NO	**CONTACT INFORMATION:**	_____

10. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY):

☐ **HOSPITAL BED** ☐ **GURNEY** ☐ **WHEEL CHAIR** ☐ **AMBULATORY** ☐ **SPECIAL MATTRESS**	☐ **IV PUMPS** ☐ **OXYGEN** ☐ **VENTILATOR** ☐ **BLOOD GLUCOSE MONITOR** ☐ **RESPIRATORY EQUIPMENT**	☐ **SERVICE ANIMAL** ☐ **G TUBE PUMP** ☐ **MONITOR** ☐ **OTHER** ☐ **OTHER**	☐ **FOLEY CATHETER** ☐ **OTHER** ☐ **OTHER** ☐ **OTHER** ☐ **OTHER**

ISOLATION:	☐ YES ☐ NO	**TYPE:**	_____

11. DEPARTMENT LOCATION			
ROOM#:		**TIME:**	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD SENT:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG SENT:	☐ YES ☐ NO		
BELONGINGS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
VALUABLES:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		
MEDICATIONS:	☐ WITH PATIENT ☐ LEFT IN ROOM ☐ NONE		

12. ARRIVING LOCATION			
ROOM#:		**TIME:**	
ID BAND CONFIRMED:	☐ YES ☐ NO		
ID BAND CONFIRMED BY:			
MEDICAL RECORD RECEIVED:	☐ YES ☐ NO		
FACE SHEET/TRANSFER TAG RECEIVED:	☐ YES ☐ NO		
BELONGINGS RECEIVED:	☐ YES ☐ NO		
VALUABLES RECEIVED:	☐ YES ☐ NO		
MEDICATIONS RECEIVED:	☐ YES ☐ NO		

13. SPECIAL CONSIDERATIONS			
TIME TO STAGING AREA:		**TIME DEPARTING TO RECEIVING FACILITY:**	
DESTINATION:		**ARRIVAL TIME:**	
TRANSPORTATION:	☐ **AMBULANCE UNIT** ☐ **HELICOPTER** ☐ **BUS** ☐ **OTHER:** _____		
ID BAND CONFIRMED:	☐ YES ☐ NO	**ID BAND CONFIRMED BY:**	

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR EACH RESIDENT TRANSFERRED TO ANOTHER FACILITY
ORIGINATION: OPERATIONS SECTION – ADMIT/TRANSFER & DISCHARGE UNIT
ORIGINAL TO: RECEIVING FACILITY
COPIES TO: PLANNING