

Psychiatric Health Facility Patient Emergency Tracking Log

Incident Name	Operational Period	Total # of Staff on Unit at Incident Start								
		LVNs/ PTs	RNs	PAs/ NPs	MDs/ DOs	Admin	SW	RT	Other	TOTAL
	Date: _____ to _____ Time: _____ to _____									

Patient Name	Current Location	Date/Time	Transfer Initiated	Evacuation Triage Category	Transferred to	Transfer Location Contact Name and Phone #
		Date: _____ Time: _____	Date: _____ Time: _____	<input type="checkbox"/> Standard <input type="checkbox"/> Immediate		
Patient Risk Factors:	Current Location	Date/Time	Medical Record Sent	Medication Sent	Family Notified	Transfer Completed
<input type="checkbox"/> Medical <input type="checkbox"/> Seclusion/Restraint <input type="checkbox"/> Fall <input type="checkbox"/> Suicide <input type="checkbox"/> Elopement		Date: _____ Time: _____	Yes No	Yes No	Yes No	Date: _____ Time: _____

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Prepared By
NAME: _____ SIGNATURE: _____

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