Assisted Living Disaster Struck Facility #2

## ATTACHMENT A: PATIENT / MEDICAL RECORD & EQUIPMENT TRACKING SHEET

| Patient MR # or Tracking # | Date of Birth | Patient Name | Sex | Time Left Bldg. | Name, Type of and # Transport (State if applicable) | Original Chart Sent w/ Patient (Y) (N) | Meds & MAR Sent w/ Patient (Y) (N) | Equipment Sent | Family Notified: Name, Date & Time, Phone Number w/ Area Code | | | PCP Notified Name, Phone Number, Date & Time | | | Time Arrived Stop-over / Time Left | Time/ Date Arrived at Patient Accepting Facility |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Y | N | | Y | N | | | |
| 11 | 7/7/45 | AL Resident 1 | M | 9:30Am | MAP Member Bus #2 | Y | Y | Cane | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 12 | 11/19/39 | AL Resident 2 | M | 9:30Am | | Y | Y | Cane | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 13 | 11/2/50 | AL Resident 3 | M | 9:30Am | | Y | Y | Walker | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 14 | 8/24/49 | AL Resident 4 | F | 9:30Am | | Y | Y | NONE | ✓ | | Son 9:15 Am | ✓ | | | A L | |
| 15 | 8/20/38 | AL Resident 5 | M | 9:30Am | | Y | Y | Walker | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 16 | 10/31/61 | AL Resident 6 | M | 9:30Am | | Y | Y | Walker | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 17 | 11/20/36 | AL Resident 7 | M | 9:30Am | | Y | Y | Cane | ✓ | | Daughter 9:15 Am | ✓ | | | A L | |
| 18 | 5/14/34 | AL Resident 8 | F | 9:30Am | | Y | Y | Cane | ✓ | | Son 9:15 Am | ✓ | | | A L | |
| 19 | 3/1/55 | AL Resident 9 | F | 9:30Am | | Y | Y | NONE | ✓ | | Son 9:15 Am | ✓ | | | A L | |
| 20 | 10/17/36 | AL Resident 10 | F | 9:30Am | ✓ | Y | Y | Walker | ✓ | | Son 9:15 Am | ✓ | | | A L | |

**Disaster Struck Facility: Keep One Copy / ☐ FAX 1 copy to RCC / ☐ FAX 1 copy to Receiving Facility / ☐ GIVE 1 copy to Transporters**

**Patient Accepting Facility: Have you communicated to RCC or Disaster Struck Facility that you received these residents? ☐ YES / ☐ NO**

**Patient Accepting Facility: Print Name of Key Contact / Phone # / Fax:**_____

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #2 PHONE _____

RESIDENT'S NAME AL Resident 1 DOB 7/7/1945

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

COPD, CHF, HTN

TREATMENTS: Lasix, ASA, Lisinopril, Xopenex

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization _____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / (N))
Alert ☒ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☒ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☒ Deaf ☐ Hearing Aid (L) / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type _____ Rate _____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☒ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT

IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME OSF#2 PHONE _____

RESIDENT'S NAME AL Resident 2 DOB 11/19/1939

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

UTI, PNU

TREATMENTS: ASA, Senna, Zaporex

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / (N))
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☑ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☐ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☒ Deaf ☐ Hearing Aid L / R Dentures (U) / L Contact Lens ☐

DIET
Diabetic ☑ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☑ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☑ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☑ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF#2 PHONE _____

RESIDENT'S NAME AL Resident 3 DOB 11/2/1950

LANGUAGE(s) SPOKEN English, French ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

Dementia, Anemia, Pacemaker

TREATMENTS: Senna, Tran

ALLERGIES: Peanuts

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia (Y) / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☒ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☒ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☒ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☒ Deaf ☐ Hearing Aid L / (R) Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☒ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☒ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #2 PHONE _____

RESIDENT'S NAME AL Resident 4 DOB 8/24/1949

LANGUAGE(s) SPOKEN English Spanish ABLE TO COMMUNICATE Y / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

HTN, EDDM, CHF

TREATMENTS: Amlodipine, Lasix, Colace, Insulin

ALLERGIES: NKDA

FACILITY PHARMACY: Walgreens PHONE: _____

DNR ORDER: Y / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☑ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☑ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☑ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☑ Last Insulin 8AM Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☑ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☑ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☑ Cane ☐ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT

IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME RSF #2 PHONE _____

RESIDENT'S NAME AL Resident 5 DOB 8/20/1938

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

S/p AVR Replacement

TREATMENTS: Colace, Ambien, Motrin

ALLERGIES: NKOA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / (N))
Alert ☒ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☒ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures (U) / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☒ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF # 2 PHONE _____

RESIDENT'S NAME AL Resident 6 DOB 10/31/1961

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

Dementia, CHF

TREATMENTS: ASA, Lasix, Aricept,

ALLERGIES: PCN

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: (Y) / N Other _____ No Hospitalization _____
(attach MOLST Form)

MENTAL STATUS (Dementia: (Y) / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☒ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☒ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☒ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☒ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type _____ Rate _____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☒ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME ADF #2 PHONE _____

RESIDENT'S NAME AL Resident 7 DOB 11/20/1936

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE Y / N

FAMILY CONTACT Daughter PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

~~EIDDM~~, HTN, CVA, Seizures

TREATMENTS: Clarity, Diazepam, Insulin

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☒ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☑ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☒ Last Insulin 8AM Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☐ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☒ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☑

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #2 PHONE _____

RESIDENT'S NAME AL Resident 8 DOB 5/14/1934

LANGUAGE(s) SPOKEN English Polish ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

RF, T2DM, CHF, HTN, Dialysis

TREATMENTS: Furosemide, K+, Metformin, Lasix, ASA

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: (Y) / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / (N))
Alert ☒ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☒ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☒

DIET
Diabetic ☒ Last Insulin 8AM Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☒ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT

IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☑ T/TH/Sa

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF-AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSP #2 PHONE _____

RESIDENT'S NAME AL Resident 9 DOB 3/1/1955

LANGUAGE(s) SPOKEN English, French ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE _____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

IDDM, Rheumatoid Arthritis, A-Fib

TREATMENTS: Prednisone, Lantus, Coumadin

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: Y / (N) Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: Y / N)
Alert ☒ Lethargic ☐ Oriented ☐ Confused: Mildly ☐ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☒ Wanders ☐ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☐ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☒ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☒ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☒ Last Insulin 8 AM Last Meal 8 AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☒ Cane ☐ Walker ☐ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT

IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT B: RESIDENT EMERGENCY EVACUATION TAG

FACILITY NAME DSF #2 PHONE_____

RESIDENT'S NAME AL Resident 10 DOB 10/17/1930

LANGUAGE(s) SPOKEN English ABLE TO COMMUNICATE (Y) / N

FAMILY CONTACT Son PHONE_____

CRITICAL DIAGNOSIS AND CRITICAL MEDICATIONS: _____

CVA, Dementia

TREATMENTS: Risperdal, Colace, Synthroid

ALLERGIES: NKDA

FACILITY PHARMACY: Omnicare PHONE: _____

DNR ORDER: (Y) / N Other _____ No Hospitalization_____
(attach MOLST Form)

MENTAL STATUS (Dementia: (Y) / N)
Alert ☐ Lethargic ☐ Oriented ☐ Confused: Mildly ☒ Severely ☐

BEHAVIOR PROBLEMS / SAFETY RISK
None ☐ Wanders ☒ Verbally Aggressive ☐ Physically Aggressive ☐
Severe Behaviors ☐ Elopement/ Flight Risk ☒ Risk for Falls ☐

ADL'S / APPLIANCES
Independent ☒ Supervision ☐ Partial Assist ☐ Total Assist ☐
Continent ☐ Incontinent Bladder ☐ Incontinent Bowel ☐ Catheter/ Ostomy ☐
Blind ☐ Glasses ☐ Deaf ☐ Hearing Aid L / R Dentures U / L Contact Lens ☐

DIET
Diabetic ☐ Last Insulin _____ Last Meal 8AM Kosher ☐

Thickened Liquids ☐ Consistency: _____

NPO ☐ Aspiration Precautions ☐ Modified Diet _____

Tube Feed ☐ Type_____ Rate_____

TRANSFERS
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2
Mechanical ☐ Total ☐

MOBILITY
Independent ☒ Supervision ☐ Partial Assist ___ of 1 2 Total ☐

EQUIPMENT: None ☐ Cane ☐ Walker ☒ Wheelchair ☐

SPECIAL PRECAUTIONS / PROCEDURES / EQUIPMENT
IV ☐ Access Type _____ Infectious Disease ☐ Type _____ C-Dif ☐

Ventilator ☐ Trach ☐ Speaking Valve ☐ Dialysis ☐

Suction ☐ How Often _____ Seizure Precautions ☐

$O_2$ Rate _____ Mask _____ Cannula _____ Continuous _____ PRN _____

Restraint: Type _____ When Last Released _____

OTHER: _____

RESIDENT ACCEPTING FACILITY: RAF - AL

PHONE # _____ CONTACT _____

**Document all care provided to Resident *DURING TRANSFER* and/or concerns in the space below**

# ATTACHMENT C: INFLUX OF PATIENTS LOG

**(Accounting for Incoming Patients and Equipment)**

Make additional copies prior to use

| 1. FACILITY NAME | 2. DATE/TIME PREPARED | 3. INCIDENT DESCRIPTION |
|---|---|---|
| | | |

**4. TRIAGE AREA (for entry into the facility)**

| Arrival Time | Facility Received From | MRN# / Triage # | Pt Name (Last, First) | Sex | DOB/ Age | Original Chart Received w/ Resident (Y) (N) | Meds & MAR Received w/ Resident (Y) (N) | Equipment Received | Family Notified: Name, Date, Time, Phone Number w/ Area Code | | | PCP Notified: Name, Date, Time, Phone Number w/ Area Code | | | Time Left Triage/ Destination |
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| 5. SUBMITTED BY | 6. PHONE NUMBER | 7. DATE/TIME SUBMITTED |
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# ATTACHMENT C: INFLUX OF PATIENTS LOG

**(Accounting for Incoming Patients and Equipment)**

Make additional copies prior to use

| 1. FACILITY NAME | 2. DATE/TIME PREPARED | 3. INCIDENT DESCRIPTION |
|---|---|---|
| 4. TRIAGE AREA (for entry into the facility) | | |

| Arrival Time | Facility Received From | MRN# / Triage # | Pt Name (Last, First) | Sex | DOB/ Age | Original Chart Received w/ Resident (Y) (N) | Meds & MAR Received w/ Resident (Y) (N) | Equipment Received | Family Notified: Name, Date, Time, Phone Number w/ Area Code | | | PCP Notified: Name, Date, Time, Phone Number w/ Area Code | | | Time Left Triage/ Destination |
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| 5. SUBMITTED BY | 6. PHONE NUMBER | 7. DATE/TIME SUBMITTED |
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