ATTACHMENT 12: PATIENT IDENTIFICATION TRACKING FORM

Purpose: Assist in identifying, tracking, and reunifying patients during a disaster.

Instructions: This form should be completed to the best of the ability given the information available on all patients, especially pediatric patients, who arrive at a health care facility regardless if accompanied by family/parent/guardian. Send the original form with the patient if transferred to another facility and keep a copy of the form on file with the patient's medical record at the transferring health care facility.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival	Time of Arrival AM/PM	Incident name
Tracking number (assigned by transferring health care facility)		
Patient's Name (Last, First)		Patient's Phone
Patient's Full Home Address		
(For Minors) Parent/Guardians' Names		Presented with patient? ☐ Yes ☐ No
Patient's DOB ☐ Unknown	Age Years Months ☐ Estimated	Gender ☐ Male ☐ Female
Race/ethnicity, if known ☐ White non-Hispanic ☐ Black/African American, non-Hispanic ☐ Asian or Pacific Islander ☐ Hispanic ☐ Asian Indian ☐ American Indian or Alaska Native ☐ Unknown ☐ Other		Language ☐ English ☐ Spanish ☐ Nonverbal ☐ Other

☐ Accompanied ☐ Unaccompanied	Describe where patient was found. Be as specific as possible, including neighborhood/street address.	Items worn by or with patient when found (describe color, pattern, type)
How patient arrived at hospital (list name if available) ☐ EMS ☐ Private medical transport service (ambulance/flight) ☐ ☐ Law Enforcement ☐ ☐ Private Vehicle ☐ Walk-in ☐ Other		☐ Pants ☐ Shirt ☐ Dress ☐ Shoes ☐ Socks ☐ Coat/Jacket ☐ Jewelry ☐ Glasses ☐ Medical devices ☐ Other ☐ Other

DESCRIPTION OF THE PATIENT

Skin color	Attach photo here
Hair Color ☐ Blonde ☐ Brown ☐ Black ☐ Bald ☐ Red ☐ Grey ☐ White ☐ Other	
Eye Color ☐ Brown ☐ Blue ☐ Green ☐ Other	
Height ☐Estimated	
Weight ☐Estimated	
Other markings ☐ Scars ☐ Moles ☐ Birthmarks ☐ Tattoos ☐ Missing teeth ☐ Braces ☐ Other ☐ Other	

PATIENT TRACKING LOG

Hospital/Facility Name	**Phone Number**	**Arrival Date**	**ID Band #/ ID Band**
Location (city, state)	**Fax Number**	**Departure Date**	*(If patient has ID bands from other facilities and they need to be removed to provide care, attach ID band in this area)*

MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY

Does the patient have any pre-existing medical conditions, medical problems, previous surgeries, special needs?
□ No □ Unknown □ Yes (list)

Is the patient on any medications? □ No □ Unknown □ Yes (list)

Does the patient have any allergies? □ No □ Unknown □ Yes (list)

Did the patient receive medical care for an injury/illness while at this facility?
□ No □ Yes (list)

COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN

Name of Person Accompanying Child ☐ Adult ☐ Child/Minor

Relationship to Child
□ Parent □ Guardian □ Sibling □ Grandparent
□ Aunt/Uncle/Cousin □ Unknown
□ Other

Attach Copy of ID

ID Checked? □ Yes □ No
Form of ID (list)

If accompanied by adult, was child living with this adult prior to the emergency? □ Yes □ No
Does this adult have any proof of legal guardianship or relationship? □ Yes □ No
If yes, make copy and attach to this form.

If child and adult were separated after arrival at current facility, where is accompanying adult now?

If accompanied by someone other than parent/guardian, what is known about the parent/guardian's current whereabouts?
□ Nothing at this time □ Their current location is:

Is it known if there are orders of protection or other custody issues? □ No known custody/protection issues
□ Issue(s) identified

COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN

Are the whereabouts of the parent/guardian currently known? □ No □ Yes
Is information about parent/guardian known? □ No □ Yes
Name Phone
Location
E-mail Address

Where and when was the parent/guardian last seen

Has the parent/guardian been contacted □ No □ Yes
Contacted by Date Time

Plans for reuniting child with parent/guardian

Agencies Used to Assist with Reunification (Date/Person Contacted)
□ American Red Cross
□ Illinois Department of Children and Family Services
□ Law enforcement
□ National Center for Missing and Exploited Children

□ Other

Additional steps to verify guardianship if reunited at hospital
□ Does parent/guardian describe child accurately?
□ Does parent/guardian pick correct child out from a group of pictures?
□ Does parent/guardian have a picture of them with the child?
□ Does the child respond appropriately when reunited with parent/guardian?

DISPOSITION

□ Admitted to_____ □ Discharged □ Expired
□ Patient was released to an individual □ Parent □ Guardian □ Other
Name Phone License Plate Number
Address □ Permanent □ Temporary
Was consent obtained from parent/guardian if released to another adult? □ Yes □ No (explain)

□ Patient was transferred to another facility/agency (Name)
Address Phone
Contact Name
Transported by

Signature of patient/individual patient released to	Date: Time:	Name of Person Completing Form
		Signature of Person Completing Form