Family or Caregiver Transportation Sign Out Log
PLEASE COMPLETE ALL THE COLUMNS

- **Resident Name:** ____________________ **DOB:** ___________
- **Time Out:** ____________ **Time In:** ____________
- **Escort Name:** __________________ **Relationship:** ______________
- **Purpose of Trip: (check all that apply)**

_____Medical trip (clinic visit)
_____Medical trip (lab, imaging, testing)
_____Medical trip (procedure)
_____Medical trip (chemo or radiation)
_____Medical trip (dialysis)
_____Non-medical trip (please describe)

____

Transport Type: (select one)

- ☐ Personal Vehicle
- ☐ Wheelchair Van
- ☐ Stretcher

Was Food, Beverage, or Medicine Consumed?

Medicine(s): (please write medicine, dosage, reason, and time of administration below)

____N/A

Food(s) (please write type, texture, and amount below)

____N/A

Soft Drink (please list type and amount below)

____N/A

Alcohol (please list type and amount below)

____N/A

Were there issues on the trip? (check all that apply)

- ☐ Fall
- ☐ Incontinence (bowel, bladder, both)
- ☐ Medical Device Issue (IV, catheter, oxygen, feeding tube, continuous glucose monitor, cast, brace etc). Please describe: ___________________________________
- ☐ Skin Tear
- ☐ Nausea/Vomiting
- ☐ Allergic Reaction
- ☐ Other ____________________________
- ☐ No Issues

If issue, was patient taken to urgent care, ER, or hospital? (provide name and location below)

Non-Emergent Medical Transport or Facility Van Transport Form

PLEASE COMPLETE ALL THE COLUMNS

- **Resident Name:** ____________________ **DOB:** __________
- **Time Out:** ____________ **Time In:** ___________
- **Name of Transporter:** _________________________________

Transport Type: (select one)
- ☐ Wheelchair Van
- ☐ Stretcher
- ☐ Other: ______________________________

Purpose of Trip: (check all that apply)
- ☐ Medical trip (clinic visit)
- ☐ Medical trip (lab, imaging, testing)
- ☐ Medical trip (procedure)
- ☐ Medical trip (chemo or radiation)
- ☐ Medical trip (dialysis)
- ☐ Non-medical trip (please describe) _________________________________

Medical Device Presence: (please check if present)

___Peripheral IV ___Oxygen
___Central Line ___Walker
___Feeding Tube ___Cane
___Wound Vac ___Wheelchair

Any issues (please explain): _______________ ____

Logistics:
- ☐ Pick-up
- ☐ Drop-off
- ☐ Round trip
- ☐ Go Between (from Appt A to Appt B)

Logistical Issues: check all that apply
- ☐ Patient lost
- ☐ Unable to be seen (cancellation)
- ☐ Unable to be seen (appointment information was incorrect)
- ☐ Unable to be seen (accessibility issue)
- ☐ Unable to be seen (delayed arrival)
- ☐ Patient hospitalized
  - ___ Sent to ER and driver not notified
  - ___ Sent to ER and driver notified
  - ___ Direct to ER from Van

Time Lost: ____________________________ (total unnecessary time loss)

Adverse Events: (check and complete all that apply)

____ **Skin tears** (location): __________________________ **# of skin tears**: ______________
- ☐ Mild (band-aid appropriate, little blood)
- ☐ Moderate (large bandage/patch needed, significant blood)
- ☐ Severe (laceration, lot of blood, skilled assistance required (e.g. hospital)

____ **Incontinence Episode**:
- ☐ Urination
- ☐ Bowel movement
- ☐ Type of Incontinence Unclear

____**Allergic Reaction**: (please describe) ____

____ **Nausea only**:

____ **Nausea & Vomiting**:

____**Fall from standing position**:
- ☐ Without injury
- ☐ With injury (please describe): ____

____**Fall from seated position**
- ☐ Without injury
- ☐ With injury (please describe): ____

Was Food, Beverage, or Medicine Consumed?

Medicine(s): (please write medicine, dosage, reason, and time of administration below)
____N/A

Food(s) (please write type, texture, and amount below)
____N/A

Soft Drink (please list type and amount below)
____N/A

Alcohol (please list type and amount below)
____N/A