|  |  |  |  |
| --- | --- | --- | --- |
| 1. Event Type: Real World Exercise | | 2. Submittal Date: Time: | |
| 3. Name of Facility: | | 4. Event/Incident Title: | |
| 5. Report Type: Initial Revised Final: | | | |
| 6. Contact Name: | | 7. Phone Number: | |
| 8. Contact Fax Number: | | 9. Contact Email: | |
| 10. ICC Activated? Yes No | | 11. ICC Phone: | |
| 12. ICC Email: | | 13. ICC Fax: | |
| 14. Facility Type: Hospital LTC Clinic Urgent Care Other: | | | |
| Incident Type: (See Below) | | | |
| Communications/IT Fire/Explosion Lockdown/Security Patient Surge  Hazardous Materials Severe Weather Utility Failure Labor Disruption Flood Other, specify: | | | |
| 16. Evacuation: Yes No Partial Evacuation Sheltering in Place Full Evacuation | | | |
| 17. Check the most appropiate level of functionality of your facility:  Fully Functional Partially Functional Not Functional | | | |
| 18. Prognosis: Worsening No Change Improving: | | | |
| 19. Can your Facility provide essential patient care? Yes No: | | | |
| 20. Can your Facility take more patients? Yes No If Yes, Number of patients | | | |
| 21. Can your Urgent Care/Emergency Department take more patients? Yes No  If Yes, Number of patients: | | | |
| 22. Provide a brief description of the situation and/or infrastructure status: | | | |
| 1. Do you have STAFFED BEDS AVAILABLE? (personnel staffing with beds based on HAvBED definitions) Med/Surg Yes No # of Beds: OR Yes No # of Suites: Peds Yes No # of Beds: Vents Yes No # of Vents: Adult ICU Yes No # of Beds: OB/GYN Yes No # of Beds: NICU Yes No # of Beds: Psych Yes No # of Beds: Trauma Yes No # of Beds: Isolation Yes No # of Beds:   Yes No # of Beds: LTC Yes No # of Beds:   1. Is Decon Available? Yes No Limitations? | | | |
| 25. Number of Casualties – How many patients do you have as a result of this event? START Triage | | | |
| 26. Immediate (RED): | 27. Delayed (YELLOW): | | 28. Minor (GREEN): |
| 29. Deceased (BLACK): | 30. Treated – Admitted: | | 31. Treated – Released: |

32. Identify critical issues & resource needs that cannot be addressed by your facility. If you have resource needs, you MUST submit a Medical/Health Resource Request form

Comments

This form is to be sent from your Facility to the Medical Health Operational Area Coordinator (MHOAC) program. This form should be emailed. Email should be sent as an attachment to MHOAC program at [EMSDUTYOfficer@co.monterey.ca.us](mailto:EMSDUTYOfficer@co.monterey.ca.us) and will be received by EMS/Public Health staff. To contact MHOAC or EMS Duty Officer directly please contact AMR dispatch center at (831) 796-6444 and ask for EMS Duty Officer. In the event this process changes, either the form will change or you will be notified by the MHOAC program.