

**Alameda County Medical/Health Status Report Form** Submittal Date:  Time:

1) Event/Incident Title:  2) Facility Name:

3) Originator Name:  4) Title:  5) Department:

6) Phone:  7) Email:

8)  Hospital  Clinic  Other  9) EOC/HCC Phone #:

10) Is your EOC/HCC activated?  Not Activated  Partially Activated  Fully Activated

11) Check the most appropriate level of functionality of your facility:  
 Not Functional  Partially Functional  Fully Functional

12) Provide facility infrastructure status (damage, electricity, water, internet, phones, etc):

13) Can your facility provide essential Patient Care?  No  Yes

14) Estimated Casualties - How many patients do you have as a result of this event? (Based on START Triage)  
Immediate (Red)  Delayed (Yellow)  Minor (Green)  Deceased (Black)

15) Can your facility take more patients?  No.  Yes. 16) If yes, number of patients

17) Do you have STAFFED BEDS AVAILABLE (personnel staffing with beds)? Based on HAVBED definitions.

MED/SURG	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	OR	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
ICU	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	ISOLATION	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
PICU	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	OB/GYN	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
NICU	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	TRAUMA	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
TELE	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	BURN	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
PSYCH	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>	OTHER	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>
PEDS	<input type="radio"/> No	<input type="radio"/> Yes	# of Beds	<input type="text"/>					

18) Can your Urgent Care/Emergency Department take more patients?  No  Yes

19) If yes, number of patients  20) Explain any limitations:

Identify critical issues and resource needs that cannot be addressed by your facility:  
21) If you have any resource needs, you **MUST** submit a [Medical/Health Request Form](#).

**This form is to be sent from your Facility to the Operational Area (County EOC)**

This form should be e-mailed as an attachment to [med1@acgov.org](mailto:med1@acgov.org) and will be received by EMS staff.

**Medical Health Branch Fax number (925) 803-2720, or (925) 803-7872**

EOC medical branch phone number (925) 803-7930 or (925) 803-7818

If Reddinet is available, please check regularly for updated messages and instructions.

**For EMS Use Only:** Processed by:  Date:  Time: