Santa Clara County RACES -- Radio Routing Slip

Reset Form Rev: 190527

Radio Operator Only:	[1] Origin Msg #:	Destination Msg #:

This Section to be Completed by Message Author/Creator: (Underlined=Required)

[2] Date:	[3] Time (24hr):	[4] Handling: ○ Immediate (ASAP) ○ Priority (<1 hr) ○ Routine (<2 hr)

TO	[5] ICS Position:	FROM	[9] ICS Position:
	[6] Location:		[10] Location:
	[7] Name:		[11] Name:
	[8] Contact Info:		[12] Contact Info:

Form:	[13] Type:	[14] Topic:

Instructions for Message Author/Creator:

1. **Complete section above, surrounded by BOLD line (see instructions on back)**
2. **Fill in all Required fields**
3. **Attach to the front of a form to be sent via radio**
4. **Deliver to radio operator for transmission**

Radio Operator Only:				
Relay:	Rcvd:		Sent:	
Name:		Call Sign:	Date:	Time (24hr):

DEOC-9 ALLIED HEALTH STATUS REPORT SHORT FORM

FACILITY NAME:	FACILTY TYPE	DATE:	TIME:

Contact Name:	Phone #	Fax #

Other Phone, Fax, Cell Phone, Radio:	Incident Name and Date:

FACILITY STATUS	CHECK ONE
GREEN- FULLY FUNCTIONAL	
RED- LIMITED SERVICES	
BLACK- IMPAIRED/CLOSED	

CHECK ADDITIONAL ATTACHMENTS PROVIDED	Yes/No
NHICS/ICS ORGANIZATION CHART	
DEOC-9A RESOURCE REQUEST FORMS	
NHICS/ICS STATUS REPORT FORM - STANDARD	
NHICS/ICS INCIDENT ACTION PLAN	
PHONE/COMMUNICATIONS DIRECTORY	

FACILITY CONTACT INFORMATION	
FACILITY EOC MAIN CONTACT NUMBER	
FACILITY EOC MAIN CONTACT FAX	
FACILITY LIAISON OFFICER NAME: LIAISON TO PUBLIC HEALTH/MEDICAL HEALTH BRANCH	
FACILITY LIAISON CONTACT NUMBER	
FACILITY INFORMATION OFFICER NAME	
FACILITY INFORMATION OFFICER CONTACT NUMBER	
FACILITY INFORMATION OFFICER CONTACT EMAIL	
IF FACILITY EOC IS NOT ACTIVATED, WHO SHOULD BE CONTACTED FOR QUESTIONS/REQUESTS	
FACILITY CONTACT NUMBER	
FACILITY CONTACT EMAIL	

GENERAL SUMMARY OF SITUATION/CONDITIONS

FACILITY PATIENT FLOW INFORMATION	TOTAL
FACILITY PATIENTS TO EVACUATE	
FACILITY PATIENTS INJURED - MINOR	
FCAILITY PATIENTS TRANSFERED OUT OF COUNTY	
OTHER FACILITY PATIENT CARE INFORMATION	

SNF BED RESOURCE AVAILABILITY	Staffed Bed- M	Staffed Bed-F	Vacant Beds-M	Vacant Bed-F	*Surge #
SKILLED NURSING					
ASSISTED LIVING					
SUB-ACUTE					
ALZEIMERS/DIMENTIA					
PEDIATRIC-SUB ACUTE					
PSYCHIATRIC					

DEOC/EOC/DUTY CHIEF USE

*surge number: # of beds in addition to vacant available beds

AVAILABLE RESOURCES BY FACILITY TYPE	CHAIRS/ ROOMS	VANCANT CHAIRS/ ROOM	FRONT DESK STAFF	MEDICAL SUPPORT STAFF	PROVIDER STAFF
DIALYSIS					
SURGICAL					
CLINIC					
HOMEHEALTH					
ADULT DAY CENTER					

Please follow instructions received from email/phone/CAHAN on how to submit this form. If telephones/fax are not working, use alternate means of communication (radio, messenger, etc.) Use the RESOURCE REQUEST FORM to request resources.