Santa Clara County RACES -- Radio Routing Slip

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:**
- ⁶ **Location:**
- ⁷ **Name:**
- ⁸ **Contact Info:**

FROM
- ⁹ **ICS Position:**
- ¹⁰ **Location:**
- ¹¹ **Name:**
- 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	CHECK ADDITIONAL ATTACHMENTS PROVIDED	Yes/No
GREEN- FULLY FUNCTIONAL		NHICS/ICS ORGANIZATION CHART	
RED- LIMITED SERVICES		DEOC-9A RESOURCE REQUEST FORMS	
BLACK- IMPAIRED/CLOSED		NHICS/ICS STATUS REPORT FORM - STANDARD	
FACILITY CONTACT INFORMATION		NHICS/ICS INCIDENT ACTION PLAN	
FACILITY EOC MAIN CONTACT NUMBER		PHONE/COMMUNICATIONS DIRECTORY	
FACILITY EOC MAIN CONTACT FAX		GENERAL SUMMARY OF SITUATION/CONDITIONS	
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		SNF BED RESOURCE AVAILABILITY	Staffed Bed- M	Staffed Bed-F	Vacant Beds-M	Vacant Bed-F	*Surge #
FACILITY CONTACT NUMBER		SKILLED NURSING					
FACILITY CONTACT EMAIL		ASSISTED LIVING					
FACILITY PATIENT FLOW INFORMATION	**TOTAL**	SUB-ACUTE					
FACILITY PATIENTS TO EVACUATE		ALZEIMERS/DIMENTIA					
FACILITY PATIENTS INJURED - MINOR		PEDIATRIC-SUB ACUTE					
FCAILITY PATIENTS TRANSFERED OUT OF COUNTY		PSYCHIATRIC					
OTHER FACILITY PATIENT CARE INFORMATION							

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.

ALLIED HEALTH STATUS REPORT FORM – Revised February 2018
Department Operations Center Form 9 (DEOC-9)