|  |  |
| --- | --- |
| **Incident Name:** | **Operational Period to be Covered by Situation Report (Date/Time)****From: To:** |
| **Approved By Operations Section Chief :** |  |
| **Regional Medical Situation Report**  |
| **Prepared By:** | **Date/Time:** |

*This form should be utilized in the event of a multi-casualty incident (MCI) that activates the Regional Emergency Operations Center (REOC). Information contained within this document should be incident specific. Please fill out only the sections pertinent to your facility/agency.*

*Completion of this form will begin in the second operational period and each subsequent operational period (s) until the incident is concluded. For planning purposes:*

* *IMMEDIATE needs should describe items/personnel required within the current or next operational period.*
* *ANTICIPATED needs should describe items/personnel that are not required yet but could be needed in future operational periods. Indicating this information allows the REOC to begin planning for the potential need.*

**PRE-HOSPITAL INFORMATION**

Cumulative Data:

* Since the incident until now, \_\_\_\_\_\_\_\_\_\_ patients have been transported to medical facilities.
* REMSA is currently dedicating \_\_\_\_\_\_\_\_\_\_ ambulances specifically for incident response.
* Care Flight is currently utilizing \_\_\_\_\_\_\_\_\_ air assets specifically for incident response.

Current Operational Period Data:

* In the current operational period, the following patients have been transported per facility:
	+ RRMC: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ SMRMC: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ NNMC: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ RRSM: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ VA: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ IVCH: \_\_\_\_\_ Reds \_\_\_\_\_ Yellows \_\_\_\_\_ Greens
	+ Non-Washoe County Facilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Immediate Needs:
	+ Ambulances
	+ Personnel
	+ Supplies
	+ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Anticipated Needs:
	+ Ambulances
	+ Personnel
	+ Supplies
	+ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent Information Related to Checked Items:

Additional Important Comments:

**HOSPITAL INFORMATION**

Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cumulative Data:

* + In patient census \_\_\_\_\_\_\_\_\_\_\_
	+ Estimated remaining capacity \_\_\_\_\_\_\_\_\_\_ patients
	+ Current total number of patients seen related to the MCI, until now \_\_\_\_\_\_\_\_\_\_\_

Current Operational Period Data:

* + Current Emergency Department census \_\_\_\_\_\_\_\_\_\_\_
	+ Immediate Needs:
	+ Supplies
	+ Security
	+ Activation of the Statewide Medical Surge Plan
	+ Medical volunteers
	+ Mobile Medical Facility
	+ Utilization of Alternate Care Sites

*\*\* If any of the above boxes are checked, you should complete the healthcare requesting form\*\**

* + - Supplies
		- Security
		- Activation of the Statewide Medical Surge Plan
		- Medical volunteers
		- Mobile Medical Facility
		- Utilization of Alternate Care Sites
		- Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent Information Related to Checked Items:

Additional Important Comments:

Liaison Officer Contact Information:

**URGENT CARE INFORMATION**

Urgent Care Name:

Cumulative Data:

* + Current total number of patients seen related to the MCI, until now \_\_\_\_\_\_\_\_\_\_\_

Current Operational Period Data:

* + Immediate Needs:
	+ Supplies
	+ Security
	+ Activation of the Statewide Medical Surge Plan
	+ Medical volunteers
	+ Mobile Medical Facility
	+ Utilization of Alternate Care Sites

*\*\* If any of the above boxes are checked, you should complete the healthcare requesting form\*\**

* + - Supplies
		- Security
		- Activation of the Statewide Medical Surge Plan
		- Medical volunteers
		- Mobile Medical Facility
		- Utilization of Alternate Care Sites
		- Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent Information Related to Checked Items:

Additional Important Comments:

Liaison Officer Contact Information:

**HEALTHCARE INFORMATION**

Healthcare Facility Name:

Facility Type:

Cumulative Data:

* + In patient census \_\_\_\_\_\_\_\_\_\_\_
	+ Estimated remaining capacity \_\_\_\_\_\_\_\_\_\_ patients

Current Operational Period Data:

* + Immediate Needs:
	+ Supplies
	+ Security
	+ Activation of the Statewide Medical Surge Plan
	+ Medical volunteers
	+ Mobile Medical Facility
	+ Utilization of Alternate Care Sites

*\*\* If any of the above boxes are checked, you should complete the healthcare requesting form\*\**

* + - Supplies
		- Security
		- Activation of the Statewide Medical Surge Plan
		- Medical volunteers
		- Mobile Medical Facility
		- Utilization of Alternate Care Sites
		- Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent Information Related to Checked Items:

Additional Important Comments:

Liaison Officer Contact Information:

**MEDICAL EXAMINER/CORONER OFFICE**

* Estimated Decedents \_\_\_\_\_ \_\_\_\_\_
* Level of Activation?
	+ Level 1
	+ Level 2
	+ Level 3
	+ Level 4
	+ Level 5
* Family Assistance Center :
	+ Location:
	+ FAC Director: Phone number:
	+ Call Center Location:
	+ Public Call Center Number:
	+ Call Center Director: Phone number:
* Anticipated Needs:
	+ Field Supplies:
	+ Recovery Personnel
	+ Morgue Personnel
	+ Equipment:
	+ FAC Mental Health volunteers
	+ FAC Supplies:
	+ Other:

Pertinent Information Related to Checked Items:

Additional Important Comments: