|  |  |  |
| --- | --- | --- |
| **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: