|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date:** | **Time:** | **Unit/Department:** | **Person in Charge (Name/Title)** | **URGENT NEED****(Check for Life Safety Issues)**[ ]  |
| **Phone #’s** | **Cell Phone:** | **Red Phone #** | **Fax #** |
| **# of injuries** | **Staff** | **Patient** | **Visitor** |
| Minor (First Aid Only) |  |  |  |
| Moderate |  |  |  |
| Major |  |  |  |
| Fatalities |  |  |  |
| Mental Health |  |  |  |
| **Staff Census** | **#’s** | **Staff Census** | **#’s** |
|  Clinical (RNs, LVN, etc.) |  | Managers |  |
| Physicians |  | Directors |  |
| Clerical/Support |  | Other (please specify title or type) |  |
| Supervisors |  | Other (please specify title or type) |  |
| **Patient Census** |
| Number of **Occupied Beds** in department/unit |  |
| Number of **Empty Beds** in your unit |  |
| Number of patients on **Ventilators** |  |
| Number of patients too critical for **Emergency Discharge/Transfer** |  |
| Number of patients that can be **Rapid Discharged** |  |
| # of patients requiring Assistance | **Maximum assistance****\_\_\_\_\_\_** | **Some Assistance\_\_\_\_\_\_** | **No Assistance****\_\_\_\_\_\_** |
| **Utility Issues** | **Operational (Yes/No)** | **Utility Issues** | **Operational (Yes/No)** |
| Computers |  | Telephones |  |
| Water |  | Medical Vacuums |  |
| Power |  | Oxygen |  |
| Network |  | Security Systems |  |
| Other |  | Other |  |
| **Department Immediate Needs or Safety Concerns:** |
| (write in needs here): |
| **Department Delayed Needs:** |
| (write in needs here): |
| **Operational Status** |  **Yes/No** |
| Can your department remain operational for the next 8 hours? |  |
| **Planning Section Received By:** *(To be completed in Hospital Command Center)* | **Date/Time** |
| **Submit to the Planning Section Chief in the Command Center** |