SUBJECT: **BED AVAILABILITY REPORT** REFERENCE NO. 1122.1

Hospital Name: ___________________________________

	BED AVAILABILITY	**# Available Immediately**	**# Available within 24 Hours** Complete only when checked □	**# Available within 72 Hours** Complete only when checked □
1	Medical/Surgical			
2	Telemetry			
3	Adult ICU			
4	Pediatric ICU			
5	Neonatal ICU			
6	Pediatric Bed			
7	Obstetrics/Gynecology			
8	Trauma			
9	Burn			
10	Negative Pressure/Isolation			
11	Psychiatric			
12	Operating Room			
13	Other (please define)			
14	Ventilator			
15	Mass Decontamination Available	Yes or No		

Report completed by: _________________________________
NAME

____
PHONE NUMBER

____
DATE

FAX COMPLETED FORM TO THE MEDICAL ALERT CENTER
AT (562) 906-4300
WITHIN 60 MINUTES OF REQUEST