Santa Clara County RACES -- Radio Routing Slip

Reset Form Rev: 190527

Radio Operator Only:	[1] Origin Msg #: MPP-024	Destination Msg #:

This Section to be Completed by Message Author/Creator: (Underlined=Required)

[2] Date: 08/20/2019	[3] Time (24hr): 20:40	[4] Handling: ○ Immediate (ASAP) ◉ Priority (<1 hr) ○ Routine (<2 hr)

TO	[5] ICS Position: Medical Health Branch	FROM	[9] ICS Position: Charge Nurse
	[6] Location: XSC EOC		[10] Location: Molina Senior Healthcare
	[7] Name:		[11] Name:
	[8] Contact Info:		[12] Contact Info:
Form:	[13] Type: Allied Health Status Report		[14] Topic: Gas Leak - Evacuating

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):

Instructions: Radio Routing Slip

Purpose: The SCCo RACES Radio Routing Slip is used to add the necessary radio handling information to an existing form that does not already have these fields.

Instructions for Message Authors/Creators:

Field	Instructions
Date	Required. Enter the date created.
Time	Required. Enter the time created. Use 24-hour time.
Handling	Required. Select one. Messages are sent in priority order and as soon as possible. Indicated times are approximate maximum wait times if radio net is busy.
TO / FROM	If needed, radio operator can suggest most appropriate TO position and location.
ICS Position	Required. Enter the ICS position name.
Location	Required. Enter the location (such as name of EOC, hospital, base, command post, shelter, …).
Name	Optional. Enter only if the message is to/from a specific individual.
Contact Info	Optional. Enter a phone number, frequency or other info that may help reach the person or position.
Form	This info will aid in matching the associated form if this routing slip becomes separated.
Type	Required. Enter the type of the attached form. Example: "213RR"
Topic	Required. Enter the topic/subject of the attached form. Example: "Barricades"

Instructions for Radio Operators:

Important: Write the Origin message number on the top right of the attached form, in case it becomes separated. Staple this routing slip to the front of the form being handled. Fields are numbered in the order they should be sent over the air.

Field	Instructions
Origin Msg #	Required. Enter the message number of the original sending station.
Destination Msg #	Required. Enter the message number of the ultimate destination station.
Relay	When relaying: Enter a call sign and/or time, or other useful mark or info, to indicate status.
Name	Required. Enter the first initial and last name of the radio operator that handled the message.
Call Sign	Required. Enter the call sign of the radio operator that handled the message.
Date	Required. Enter the date the message was sent/received.
Time	Required. Enter the time the message was sent/received. Use 24-hour time.

DEOC-9 ALLIED HEALTH STATUS REPORT SHORT FORM

FACILITY NAME:	FACILTY TYPE	DATE:	TIME:
Molina Senior Healthcare	Skilled Nursing	08/20/19	2000

Contact Name:	Phone #	Fax #
Robertt Davison	408-555-7853	

Other Phone, Fax, Cell Phone, Radio:	Incident Name and Date:
	Plaque outbreak 08/01/19

FACILITY STATUS	CHECK ONE
GREEN- FULLY FUNCTIONAL	
RED- LIMITED SERVICES	
BLACK- IMPAIRED/CLOSED	X

CHECK ADDITIONAL ATTACHMENTS PROVIDED	Yes/No
NHICS/ICS ORGANIZATION CHART	
DEOC-9A RESOURCE REQUEST FORMS	
NHICS/ICS STATUS REPORT FORM - STANDARD	
NHICS/ICS INCIDENT ACTION PLAN	
PHONE/COMMUNICATIONS DIRECTORY	

FACILITY CONTACT INFORMATION	
FACILITY EOC MAIN CONTACT NUMBER	408-555-7800
FACILITY EOC MAIN CONTACT FAX	
FACILITY LIAISON OFFICER NAME: LIAISON TO PUBLIC HEALTH/MEDICAL HEALTH BRANCH	Sandra Smithe
FACILITY LIAISON CONTACT NUMBER	408-555-7831
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	
FACILITY CONTACT NUMBER	
FACILITY CONTACT EMAIL	

GENERAL SUMMARY OF SITUATION/CONDITIONS

We have been told to evacuate due to gas main leak 1/2 block away. Need to transfer patients.

FACILITY PATIENT FLOW INFORMATION	TOTAL
FACILITY PATIENTS TO EVACUATE	22
FACILITY PATIENTS INJURED - MINOR	0
FCAILITY PATIENTS TRANSFERED OUT OF COUNTY	0
OTHER FACILITY PATIENT CARE INFORMATION	

SNF BED RESOURCE AVAILABILITY	Staffed Bed- M	Staffed Bed-F	Vacant Beds-M	Vacant Bed-F	*Surge #
SKILLED NURSING					
ASSISTED LIVING					
SUB-ACUTE					
ALZEIMERS/DIMENTIA					
PEDIATRIC-SUB ACUTE					
PSYCHIATRIC					

*surge number: # of beds in addition to vacant available beds

DEOC/EOC/DUTY CHIEF USE

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.