

# Santa Clara County RACES -- Radio Routing Slip

Rev: 190527

Radio Operator Only:	<sup>1</sup> Origin Msg #:	Destination Msg #:
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<b>This Section to be Completed by Message Author/Creator:</b>				<u>(Underlined=Required)</u>	
<sup>2</sup> <u>Date:</u>		<sup>3</sup> <u>Time</u> (24hr):		<sup>4</sup> <u>Handling:</u> <input type="radio"/> Immediate (ASAP) <input type="radio"/> Priority (<1 hr) <input type="radio"/> Routine (<2 hr)	
<b>T O</b>	<sup>5</sup> <u>ICS Position:</u>			<b>F R O M</b>	
	<sup>6</sup> <u>Location:</u>				<sup>9</sup> <u>ICS Position:</u>
	<sup>7</sup> <u>Name:</u>				<sup>10</sup> <u>Location:</u>
	<sup>8</sup> <u>Contact Info:</u>				<sup>11</sup> <u>Name:</u>
			<sup>12</sup> <u>Contact Info:</u>		
<b>Form:</b>	<sup>13</sup> <u>Type:</u>			<sup>14</sup> <u>Topic:</u>	

**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

<b>Radio Operator Only:</b>			
<b>Relay:</b>	<b>Rcvd:</b>	<b>Sent:</b>	
<b>Name:</b>	<b>Call Sign:</b>	<b>Date:</b>	<b>Time (24hr):</b>

## 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
<b>Date</b>	<u>Required</u> . Enter the date created.
<b>Time</b>	<u>Required</u> . Enter the time created. Use 24-hour time.
<b>Handling</b>	<u>Required</u> . 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.
<b>TO / FROM</b>	If needed, radio operator can suggest most appropriate TO position and location.
<b>ICS Position</b>	<u>Required</u> . Enter the ICS position name.
<b>Location</b>	<u>Required</u> . Enter the location (such as name of EOC, hospital, base, command post, shelter, ...).
<b>Name</b>	Optional. Enter only if the message is to/from a specific individual.
<b>Contact Info</b>	Optional. Enter a phone number, frequency or other info that may help reach the person or position.
<b>Form</b>	This info will aid in matching the associated form if this routing slip becomes separated.
<b>Type</b>	<u>Required</u> . Enter the type of the attached form. Example: "213RR"
<b>Topic</b>	<u>Required</u> . 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
<b>Origin Msg #</b>	<u>Required</u> . Enter the message number of the original sending station.
<b>Destination Msg #</b>	<u>Required</u> . Enter the message number of the ultimate destination station.
<b>Relay</b>	When relaying: Enter a call sign and/or time, or other useful mark or info, to indicate status.
<b>Name</b>	<u>Required</u> . Enter the first initial and last name of the radio operator that handled the message.
<b>Call Sign</b>	<u>Required</u> . Enter the call sign of the radio operator that handled the message.
<b>Date</b>	<u>Required</u> . Enter the date the message was sent/received.
<b>Time</b>	<u>Required</u> . Enter the time the message was sent/received. Use 24-hour time.





# COMPLETING the DEOC 9: ALLIED HEALTH STATUS SHORT FORM

**PURPOSE:** The DEOC-9 Form is used for reporting information on significant incidents. It is not intended for every incident, as most incidents are short in duration and do not require scarce resources, significant mutual aid, or additional support and attention. The DEOC-9 form contains basic information elements needed to support situational awareness and decision-making at all levels.

**Facility Contact Name:** The name of the person to be contacted with questions about this report.

**Facility Type:** Skilled Nursing, Home Health, Dialysis, Community Health Center, Surgical Center, Hospice.

**Incident Name:** Use the pre-assigned Incident Name. This assists in tracking of forms and resources.

ALLIED HEALTH STATUS REPORT SHORT FORM			
FACILITY NAME:	FACILITY TYPE:	DATE:	TIME:
Contact Name:	Phone #	Fax #	
Other Phone, Fax, Cell Phone, Radio:		Incident Name and ID #	

**Facility Status:** Provide information about the operational status of the facility.

**Facility Attachments:** Check items that are attached to this facility status report.

FACILITY STATUS	CHECK ONE	FACILITY - CHECK ATTACHMENTS PROVIDED	Yes/No
GREEN- FULLY FUNCTIONAL	<input type="checkbox"/>	NHICS/ICS ORGANIZATION CHART	<input type="checkbox"/>
RED- LIMITED SERVICES	<input type="checkbox"/>	DEOC-9A RESOURCE REQUEST FORMS	<input type="checkbox"/>
BLACK- IMPAIRED/CLOSED	<input type="checkbox"/>	NHICS/ICS STATUS REPORT FORM - STANDARD	<input type="checkbox"/>
		NHICS/ICS INCIDENT ACTION PLAN	<input type="checkbox"/>
		PHONE/COMMUNICATIONS DIRECTORY	<input type="checkbox"/>

**Facility Contact Information:** Provide Emergency Operations Center information for the facility.

**General Summary:** Quickly Summarize the situation and or any relevant conditions of the facility.

FACILITY CONTACT INFORMATION		GENERAL SUMMARY OF SITUATION/CONDITIONS	
EOC MAIN CONTACT NUMBER		<div style="border: 1px solid black; height: 100px; width: 100%;"></div>	
EOC MAIN CONTACT FAX			
NAME LIAISON TO PUBLIC HEALTH/MEDICAL HEALTH BRANCH			
CONTACT NUMBER			
INFORMATION OFFICER NAME			
CONTACT NUMBER			
CONTACT EMAIL			
IF EOC IS NOT ACTIVATED, WHO SHOULD BE CONTACTED FOR QUESTIONS/REQUESTS			
CONTACT NUMBER			
CONTACT EMAIL			

**Facility Patient Flow Information:** Provide the health status of patients, staff or others injured as a result of the incident.

**Bed Availability:** Skilled Nursing to provide information of available beds for this reporting period.

**Available Resources:** Allied facilities to provide information of available resources by facility type.

FACILITY PATIENT FLOW INFORMATION		FACILITY TOTAL	
PATIENTS TO EVACUATE			
PATIENTS INJURED - MINOR			
PATIENTS TRANSFERRED OUT OF COUNTY			
OTHER PATIENT CARE INFORMATION			

  

SNF BED RESOURCE AVAILABILITY	Staffed Bed-M	Staffed Bed-F	Vacant Bed-M	Vacant Bed-F	*Surge #
SKILLED NURSING					
ASSISTED LIVING					
SUB-ACUTE					
ALZHEIMERS/DIMENTIA					
PEDIATRIC-SUB ACUTE					
PSYCHIATRIC					
*surge number: # of beds in addition to vacant available beds					
AVAILABLE RESOURCES BY FACILITY TYPE	CHAIR	VACANT	PHYSIC	MEDICAL	
DIALYSIS					
SURGICAL					
CLINIC					
HOMEHEALTH					
ADULT DAY CENTER					

Accurate and timely completion of the DEOC-9 assists in maintaining good situational awareness of the incident, assessment of resources, resource allocation, and timely request for regional mutual aid. Please keep this document in the Communications Section of the Emergency Operations Manual for training purposes.