



# DEOC-9 ALLIED HEALTH STATUS REPORT SHORT FORM

<b>FACILITY NAME:</b>	<b>FACILITY TYPE</b>	<b>DATE:</b>	<b>TIME:</b>
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<b>Contact Name:</b>	<b>Phone #</b>	<b>Fax #</b>
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<b>Other Phone, Fax, Cell Phone, Radio:</b>	<b>Incident Name and Date:</b>
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FACILITY STATUS	CHECK ONE	CHECK ADDITIONAL ATTACHMENTS PROVIDED	Yes/No
GREEN- FULLY FUNCTIONAL		NHICS/ICS ORGANIZATION CHART	
RED- LIMITED SERVICES		DEOC-9A RESOURCE REQUEST FORMS	
BLACK- IMPAIRED/CLOSED		NHICS/ICS STATUS REPORT FORM - STANDARD	

<b>FACILITY CONTACT INFORMATION</b>	NHICS/ICS INCIDENT ACTION PLAN	
FACILITY EOC MAIN CONTACT NUMBER	PHONE/COMMUNICATIONS DIRECTORY	

FACILITY EOC MAIN CONTACT FAX	<b>GENERAL SUMMARY OF SITUATION/CONDITIONS</b>
FACILITY LIAISON OFFICER NAME: LIAISON TO PUBLIC HEALTH/MEDICAL HEALTH BRANCH	
FACILITY LIAISON CONTACT NUMBER	
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		SNF BED RESOURCE AVAILABILITY	Staffed Bed- M	Staffed Bed-F	Vacant Beds-M	Vacant Bed-F	*Surge #
FACILITY CONTACT NUMBER		SKILLED NURSING					
FACILITY CONTACT EMAIL		ASSISTED LIVING					
<b>FACILITY PATIENT FLOW INFORMATION</b>	<b>TOTAL</b>	SUB-ACUTE					
FACILITY PATIENTS TO EVACUATE		ALZHEIMERS/DIMENTIA					
FACILITY PATIENTS INJURED - MINOR		PEDIATRIC-SUB ACUTE					
FACILITY PATIENTS TRANSFERRED OUT OF COUNTY		PSYCHIATRIC					
OTHER FACILITY PATIENT CARE INFORMATION							

<b>DEOC/EOC/DUTY CHIEF USE</b>	*surge number: # of beds in addition to vacant available beds
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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.**