



HEALTHCARE FACILITY & HPP PARTNER SITUATION STATUS REPORT

1. Date: _____ 2. Time: _____ 3. Report: Initial Update #
4. Prognosis: Worsening No Change Improving

| HEALTHCARE FACILITY INFORMATION | | | | | | | | | | | | | |
|--|---------|--------|------------|--|--|-------------|---------|--|----------------|---------|----------------|--|------------|
| 5. NAME OF FACILITY: _____ | | | | | | | | | | | | | |
| 6. STREET ADDRESS: _____ | | | | | | | | | | | | | |
| 7. CITY: _____ | | | | 8. STATE: CA | | | | 9. ZIP: _____ | | | | | |
| 10. CONTACT PERSON: _____ | | | | | 11. HICS/ICS POSITION: _____ | | | | | | | | |
| 12. TELEPHONE NUMBER: _____ | | | | | 13. FAX NUMBER: _____ | | | | | | | | |
| 14. CELL/PAGER NUMBER: _____ | | | | | 15. RADIO FREQUENCY: _____ | | | | | | | | |
| 16. EMAIL ADDRESS: _____ | | | | | 17. COMMAND CENTER ACTIVATED (HCC/ICP): <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 18. ESTIMATED CASUALTIES (HICS-259) | | | | | | | | | | | | | |
| A. PTS SEEN | | | B. WAITING | | | C. ADMITTED | | | D. DISCHARGED | | E. TRANSFERRED | | F. EXPIRED |
| 19. PATIENTS AWAITING ADMISSION (EMERGENCY DEPARTMENTS ONLY) | | | | | | | | | | | | | |
| A. ICU | B. BURN | C. M/S | D. ISO | E. NICU | F. NEURO | G. OB/GYN | H. PEDS | I. PICU | J. PSYCH | K. TELE | | | |
| 20. OVERALL FACILITY STATUS | | | | | | | | | | | | | |
| <input type="checkbox"/> Fully Functional: Minor reductions in patient services; able to carry out majority of normal operating functions <input type="checkbox"/> Partially Functional: Moderate to significant reductions in patient services* <input type="checkbox"/> Non- Functional: Not suitable for continued occupancy; critically damaged or affected; unable to continue any services* | | | | | | | | | | | | | |
| 21. Briefly describe the impact on services, treatment capacity, standard operating procedures and facility: | | | | | | | | | | | | | |
| 22. MORGUE CAPACITY: A. Used _____, B. Available _____ C. N/A <input type="checkbox"/> | | | | | | | | | | | | | |
| EVACUATION | | | | | | | | | | | | | |
| 23. Is your facility planning Evacuation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already Completed | | | | | | | | 24. Patients evacuated/ to be evacuated: | | | | | |
| <input type="checkbox"/> Partial Evacuation to: _____ <input type="checkbox"/> Full Evacuation to: _____ | | | | | | | | A. # Ambulatory _____ B. # Non-ambulatory _____ | | | | | |
| HAZARD MITIGATION (HICS-261) | | | | | | | | | | | | | |
| Briefly describe the Potential/Actual hazards: (biohazards, structural, utility, traffic, etc) | | | | List the resources needed to mitigate the Potential/Actual hazard: | | | | | | | | | |
| | | | | Personnel | | Supplies | | | Transportation | | | | |
| 25. | | | | 26. | | 27. | | | 28. | | | | |
| DAMAGED INFRASTRUCTURE (HICS-251) | | | | | | | | | | | | | |
| Briefly describe the damage (electricity, gas, water, sewer, HVAC, communications systems, etc) | | | | List the resources needed to mitigate the Damaged Infrastructure: | | | | | | | | | |
| | | | | Personnel | | Supplies | | | Transportation | | | | |
| 29. | | | | 30. | | 31. | | | 32. | | | | |
| AVAILABLE RESOURCES | | | | | | | | | | | | | |
| 33. List critical resources available at your facility and deployable to other health facilities (e.g. Personnel, meds, equipment) | | | | | | | | | | | | | |



Health and Human Services Agency

INSTRUCTIONS

The Healthcare Facility Status Report Form is a tool to efficiently communicate your facility's status, during disasters, to the Medical Health Operation Area Coordinator (MHOAC). Please complete and email this form to the MHOAC once the decision has been made to activate your Emergency Operations Plan or Command Center (HCC/ICP). If you have any questions, or need assistance completing this form please contact the Shasta County Public Health Department at 225-5591.

| Question or Data Element | Instructions |
|--------------------------|---|
| 1. | Enter the date the report was completed |
| 2. | Enter the time the report was completed |
| 3. | Check if this is an Initial Report or a Revised Report |
| 4. | Check if your situation is: Worsening, No Change (stable), or Improving |
| Facility Information | Enter general information about your facility |
| #5 to #9 | Enter your physical address and location |
| #10 to #16 | Enter the name, the ICS/HICS position, and contact information for the person who can answer questions regarding the information on this form. |
| #17 | Check Yes or No, if the HCC or ICP has been activated |
| Estimated Casualties | Enter information about the numbers and type of casualties you have received during the current reporting period (in the past 12 hours). Refer to the HICS-259 Form |
| #18 A. | Enter the number of casualties treated and still under care |
| #18 B. | Enter the number of casualties waiting to be seen |
| #18 C. | Enter the number of casualties treated and admitted |
| #18 D. | Enter the number of casualties treated and discharged |
| #18 E. | Enter the number of casualties treated and transferred to another facility |
| #18 F. | Enter the number of casualties deceased |
| ED Admits Waiting | Total admissions currently being held in the Emergency Department. |
| #19 A - K | Enter the number of patients currently awaiting admission in each category. |
| Overall Facility Status | Enter your facility's functional status |
| #20 | Check the applicable facility functional status: Fully, Partially, or Not Functional |
| #21 | Enter a brief description if you are Partially or Not Functional |
| #22 A | Enter the total number of morgue spaces currently being used at your facility |
| #22 B | Enter the total number of morgue spaces currently available at your facility |
| Evacuation | Describe the impacts of this incident on: Health & Safety, Resources, and Infrastructure |
| #23 | Check Yes or No, if you are evacuating your facility. If Yes, enter destination facility (if any). |
| #24 | Enter the numbers of ambulatory and non-ambulatory patients being evacuated. |
| Hazard Mitigation | Describe potential/actual hazards and resources needed |
| #25 | Enter a description of the potential or actual hazards. Refer to the HICS-261 Form. |
| #26-28 | List the numbers of Personnel, Supplies, and Transport resources needed to mitigate the hazard |
| Damaged Infrastructure | Describe damage to the hospital infrastructure and resources needed |
| #29 | Enter a brief description of the damage to the facility infrastructure. Refer to the HICS-251 Form |
| #30-32 | List the numbers of Personnel, Supplies, and Transport resources needed to mitigate the damage |
| Available Resources | Describe damage to the hospital infrastructure and resources needed |
| #33 | Enter a description of any resources that you can deploy to other healthcare facilities or Alternate Care Sites. |

**Complete form and transmit the data to the Medical/Health
Operational Area Coordinator (MHOAC) at
Shasta County Public Health:
EMAIL: DOC45@co.shasta.ca.us**