SITREP & RESOURCE REQUEST INSTRUCTIONS

SitRep

The Healthcare Facility and HPP Partner Situation Status Report (SitRep) Form is a tool to efficiently communicate your facility's status, during disasters, to the Medical Health Operation Area Coordinator (MHOAC). Please complete and fax this form to the MHOAC once the decision has been made to activate your Emergency Operations Plan or Command Center (HCC/ICP). During extended incidents (lasting 12 hours or more) please submit this form as directed by the MHOAC. If you have any questions, or need assistance completing this form please contact the Nor-Cal EMS Agency or Public Health Department.

Question or Data Element	Instructions
A.	Check if this is an Initial Report or a Revised Report
B.	Check if this is an Advisory or Alert Report. Advisory indicates no action is required by the MHOAC. Alert indicates there is action required by the MHOAC.
C.	Enter the date and time the report was completed
D. #1 to #5	Enter your facility name and physical address
D. #6 to #12	Enter the name, the HICS/ICS position, and contact information for the person who can answer questions regarding the information on this form.
D. #13	Check Yes or No, to indicate the HCC or ICP has or has not been activated.
E.	Select your facility's overall operational situation status.
F.	Select your facility's overall infrastructure status.
G.	Enter the numbers of staff ill, absent, needed/requested
H.	Enter your patient census information to include your capacity for accepting patients
I.	Select the status that best describes your situation: No change (stable), Improving, or Worsening
J.	Describe your current situation in as much detail as possible, include potential and actual hazards.
K.	Describe your current priorities ("None" or "Nothing to Report" is acceptable)
L.	Identify if evacuation is imminent and whether it will be partial or full. Indicate where patients will be evacuated to and numbers of ambulatory, wheel-chair, and bed-bound.
M.	Describe damage to the building infrastructure and resources needed to mitigate the damage
N.	Indicate if additional resources are needed and if a resource request is attached to this report.

Resource Request

The Resource Request: Medical and Health FIELD/HCF to Op Area Form is a tool to efficiently communicate your facility's unmet resource needs, during disasters, to the Medical Health Operation Area Coordinator (MHOAC). Please complete and fax this form to the MHOAC once you have exhausted or expect to exhaust resources. This form should accompany a Situation Status Report that

communicates your facility's status. If you have any questions, or need assistance completing this form, please contact the Public Health Department.

Question or Data Element	Instructions
1.	Name assigned by Incident Commander/Jurisdictional Emergency Management: Be as general as possible, i.e. March 2011 EQ or IED at Convention Center.
2a.	Use mm/dd/yyyy format
b.	Military Time is preferred, i.e. 1900 = 7:00 pm. If unable to use Military Time indicate am or pm.
c.	This is a requestor generated number. Consider using a 3 letter entity identifier (healthcare facility) or county identifier (Cal EMA county code); a dash "-"; and a 3 digit number (number of this request in sequential order). Example GMC-001 is Glenn Medical Center and their first RRMH request.
3.	The name, agency, position, contact information for the person completing this form.
4a.	Give a brief description of reason for request or duties to be performed.
b.	Provide Name, Title, Location, and contact information for who will be receiving the requested items and where they should be delivered or whom will meet the personnel, where they should arrive or stage, and what they should bring/have available to them.
5.	Check each box that applies to your order. Attach additional sheets if additional line items are needed.
6.	Check the boxes to confirm a condition has been met.
7. Item #	Each NEW line item is numbered
Priority	(E) Emergent <12 hours, (U) Urgent >12 hours or (S) Sustainment.
Detailed Description	Specifically describe the requested item by using brand, sizes, model #, dose, form (tabs vs caps vs suspension), strength, quantities, etc. Example: 3M N-95 Mask, Model #1234 size Medium or Penicillin 500mg tablets, 100 tablet/bottle. Describe type of personnel and any training qualifications needed. Example: RN w/ICU Experience, PharmD, MD w/OR Experience.
Quantity Requested	Quantity wanted based upon each, this is to simplify the ordering process. Example: Penicillin 500mg Tabs, 100 Tabs/bottle – Quantity Requested 50 = facility will receive 50000 tablets.
Expected Duration of Use	This only applies to equipment and personnel. Supplies will normally be considered expendable and will not be returned.
8.	Authorized management staff review and approve. Printed name, position, and signature are required.

Complete form and click the submit button at the upper right hand corner or fax the data to the Medical/Health Operational Area Coordinator (MHOAC) at: (530) 934-6463