Trinity County Public Health Department

**Health Care Facility & HPP Partner Situation Status Report**

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| **A. Report Type:**  Initial   Update | **B. Report Status:**  Advisory (no action)   Alert (action required) | | | | **C. Report Created:**  Date: Time: | | |
| **D. Healthcare Facility Information** | | | | | | | |
| **1. Name of Facility:** | | | | | | | |
| **2. Street Address:** | | | | | | | |
| **3. City:** | | | | **4. State:** CA | | | **5. Zip:** |
| **6. Contact Person:** | | | | **7. HICS/ICS Position:** | | | |
| **8. Telephone Number:** | | | | **9. Fax Number:** | | | |
| **10. Cell/Pager Number:** | | | | **11. Radio Frequency:** | | | |
| **12. Email Address:** | | | | **13. Command Center Activated (HCC/ICP):**  Yes  No | | | |
| **E. Overall Situation Status:** | | **F: Overall Facility Status:** | | | | **G. Staffing Status:** | |
|  GREEN: Normal operations: Situation Resolved   YELLOW Under control; NO Assistance Required   ORANGE: Modified services: Assistance from with OA   RED: Limited services: Assistance Required   BLACK: Impaired service: MAJOR Assistance Required   GREY: Unknown | |  Fully Functional   Partially Functional   Not Functional | | | | Total Employees: # Employees Absent: #   Additional Staffing Needed/Requested | |
| **H. Patient Census:** | | | | | | | |
| Number of patients at your facility: Ambulatory: Non-Ambulatory:  Accepting Patients:  Yes  No Estimated Capacity: Currently or will soon exceed licensed capacity:  Yes  No  If using EMSystems, is it updated:  Yes  No Frequency: | | | | | | | |
| **I. Prognosis:** | | | | | | | |
|  No change  Improving  Worsening | | | | | | | |
| **J. Current Situation:** (Provide detailed Situational Awareness Information) | | | | | | | |
|  | | | | | | | |
| **K. Current Priorities:** (“NONE” or “Nothing to Report” is acceptable) | | | | | | | |
|  | | | | | | | |
| **L. Evacuation:** Is your facility planning evacuation? | | | | | | | |
|  Yes  No   Partial Evacuation to:   Full Evacuation to: | | | Total patients evacuated/to be evacuated:  # Ambulatory (minor):  # Wheel-chair (delayed):  # Bed-bound (immediate): | | | | |
| **M. Infrastructure Damage:** (describe damage and/or disruption to electricity, gas, water, sewer, HVAC, communications systems, etc.) | | | | | | | |
|  | | | | | | | |
| **N. Resources:** | | | | | | | |
|  Additional Resources Needed   Resource Request Attached | | | | | | | |

**Complete form and fax the data to the Medical/Health Operational Area Coordinator (MHOAC) at: FAX: (530) 623-1297**