Please return form to PHD DOC Clinics Branch at DOCOpsCB@sbcphd.org
or fax to 805-681-5192/681-5142 alternate

PHD HCC DISASTER STATUS REPORT

(Outpatient providers give this information to the PHD Department Operation Center)

Outpatient Facility Name:		**Facility Contact**: Report Prepared By:
Phone Number:	**Fax:**	**Email:**
Incident Name:	**Report Date:**	**Report Time:**

Status: ☐ **Open-Full Function** ☐ **Open- Limited Function**
☐ **Closed Reopen on_______** ☐ **Closed Building Damaged** ☐ **Closed and Red-Tagged**

Please briefly describe the current capacity of your facility to serve your patients:

Are you experiencing higher than normal patient volume? ☐ **Yes** ☐ **No**
What percentage higher volume? (i.e. 20% higher volume of patients per day)

How many patients in the past 24 hours (8:00am-8:00am) have had a positive travel history and symptoms for ?

How many patients is your facility currently serving on daily basis?
Can you accept additional patients? If yes, how many immediately: per day?

Can we refer appropriate patients to your facility during this disaster/event? ☐ **Yes** ☐ **No**
(Please indicate on the next page any resources you need to continue or increase your services.)

What types of care can you provide (include specialty services):

Are you providing care to disaster/event victims? ☐ **Yes** ☐ **No** **Approximate number:**

Please describe any services you are providing related to the disaster or event:

Do you have patients in your facility that need a higher level of care? ☐ **Yes** ☐ **No**

What is the approximate wait time at your facility currently?

☐ **Less than 30 mins** ☐ **30 mins to 1 hour** ☐ **1 hour to 2 hours** ☐ **2 hours to 3 hours** ☐ **4 hours or more**

If you marked "Open-Limited Function" as your status, please describe your limits (e.g. staff, resources, utilities, services, hours) below:

Are you running low on any critical supply items?
☐ **Yes** ☐ **No, but anticipate shortage within 24 hours** ☐ **No**

Have you contacted your local City to request assistance with non-medical items? ☐ **Yes** ☐ **No**
Please list:

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Medical items: Please list the critical supply items, the approximate quantity remaining for each item, and about how long it will take for the item to be expended: **Complete a separate RESOURCE REQUEST FORM if you cannot obtain resources from your vendors.**		
1. Item Name/Description:	QTY Remaining:	Time Until Expended:
2. Item Name/Description:	QTY Remaining:	Time Until Expended:
3. Item Name/Description:	QTY Remaining:	Time Until Expended:
Additional Comments or Explanation:		

Are you currently short-staffed? ☐ YES ☐ No, but anticipate shortage within 24 hours ☐ No

If yes or if you anticipate a shortage within 24 hours, please list the positions and the quantities you are/will be understaffed below

If you need additional staff, you may make arrangements with other facilities to share staff or complete a Resource Request Form to request staff via the Public Health Department Operations Center:

1. Personnel Title/Description:	QTY Needed:
2. Personnel Title/Description:	QTY Needed:
3. Personnel Title/Description:	QTY Needed:

Additional Comments or Explanation:

Please describe the status of your pharmacy (if applicable):

PUBLIC INFORMATION ASSISTANCE: Please list any information that you would like to be distributed to the media for communication to your patients or the general public regarding your services (number to call, cancelled appointments, closed locations, alternate locations for care or pharmaceuticals, etc.). The PHD or County EOC will provide this information to the media.

Your Facility's Objectives for Next 24 hours (*obtain critical resources to continue care, method to locate alternate care for patients, method to provide pharmaceuticals, prepare to assure safety of building/water/utilities for before resuming operations, etc)*:

1.

2.

3.

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