CLINIC/ HOSPITAL ASSESSMENT of:

_____

Date of Report_____

From:

Unit:

Local Name of Clinic/Hospital: _____

_____

Age of Facility: _____

_____

Grid Coordinates: _____

Street Address: _____

Province: _____

Municipality: _____

City: _____

Primary POC: _____

Phone Number: _____

Fax: _____

E-mail: _____

Web: _____

ISOS Accreditation: _____

Accepts Tricare: _____

Available Clinical Services:

Emergency Department:

a. Location (floor wing)_____
b. Number of trauma beds_____
c. Trauma capacity _____
d. POC_____
e. 24 Hr. desk phone#_____

Operating Room:

a. Location (floor, wing)_____
b. Number of Suites_____

Intensive Care Unit:

a. Location (floor, wing)_____
b. Number of Beds_____
c. Number of Ventilators_____

Types of Cases Referred to other locations:

_____
_____
_____
_____

Name/location of Referral Facilities:

Name	Location	Phone#	POC

Helipad/Landing Zone (LZ)

a. Grid Coordinates: _____
b. Elevation: _____
c. General description of surface material and location_____

_____
_____
_____
_____

d. Cardinal direction and distance from emergency dept._____

_____
_____
_____

MASCAS Plan: _____

_____

_____

_____

_____

_____

_____

Patient Demographic:

a. Number of Patients Seen Daily: _____
b. Common Ailments/Injuries: _____
c. Common Treatments: _____
d. Main Rx Dispensed: _____

Hospital Facility Support:

a. Water Supplied By: _____
b. Sanitation: _____
c. Medical Waste Disposal: _____
d. Electrical Power: _____
e. Refrigeration: _____
f. Blood Bank: _____
g. Medical Resupply: _____

NOTES:

_____

_____

_____

_____

_____

EXSUM: _____

_____

_____

_____

_____

Photos: