

## Region 1 Facility Reporting Form

Please gather the following information to be communicated with the MA Dept. of Public Health

<b>Name:</b>		<b>Main Phone #:</b>	
<b>Title:</b>		<b>EOC/HCC Phone Number:</b>	
<b>Facility:</b>		<b>Date/Time completed</b>	

Please forward this completed form to:  **HMCC Duty Officer**    **OPEM Duty Officer**    **Gail Bienvenue**  
*Contact numbers are on the back page.*

<b>Does your facility require any form of assistance? (Y/N)</b> <i>Please report information in either case</i>	
Would you like any of this information shared with other facilities? (Y/N)	

**If other facilities need to contact your organization, please list contact information below**

Position	Name	Phone	Fax	Email
Liaison Officer				
Public Information Officer				

### Communications

Are there any challenges to your communications systems?    **Yes**       **No**

Communications Unit Leader	Phone	Fax	Email

Land Line Phone		HAM Radio	
Cell Service		Fixed Satellite Phone	
Texting Service		Mobile Satellite Phone	
Internal Paging System		E-mail	
External Paging System		Internet	
Emergency Phone Line		Other	

If other entities need to reach you, what is the best mode of communication? \_\_\_\_\_

If normal communications are down, what is your preferred HAM radio frequency? \_\_\_\_\_

**Resource and Assets**

Do you anticipate any resource needs?  Yes  No

Logistics Section Chief	Phone	Fax	Email

Have you requested resources?  Yes  No

- If yes, from what organization have you requested? \_\_\_\_\_
- Who is the point of contact at that organization? \_\_\_\_\_

Please indicate if you have less than 12, 24, 48 or 96 hours of supplies.

Disposable Supplies (food, paper goods, etc)	
Durable Medical Supplies (beds, wheelchairs, etc)	
Non Disposable (IV pump, wound vac, etc	
Blood Bank	
Pharmaceuticals	
Other	

**Safety and Security**

Are there any safety concerns at the hospital?  Yes  No

Safety Officer	Phone	Fax	Email

Physical Impediments:	
Structural Integrity:	
Snow Removal Activities:	
Other:	

### **Staff Roles and Responsibilities**

Do you have any staff support needs?  Yes  No

Planning Section Chief	Phone	Fax	Email

Identified staff support needs: (ex. Housing, transportation, stress debriefing)	
Identified staff <u>family</u> support needs: (ex. Child care, elder care, pet care)	
Other	

### **Utilities**

Do you have any utility needs?  Yes  No

Logistics Section Chief	Phone	Fax	Email

Please indicate if you have less than 12, 24, 48 or 96 hours of supplies.

Generators	
Fuel (Gas, Diesel)	
Potable or Non-potable Water	
Other	

### **Patient Clinical and Support Activities**

Do you have any staffing needs?  Yes  No

Operations Section Chief	Phone	Fax	Email

<i>Staffing Type</i>	<i>Expertise needed</i>
Medical	
Nursing	
Technical	
Support (ancillary)	

Support (licensed)	
Renal Dialysis	
In-patient	
VNA	
ED	
Discharges	
Out-patient services	
Other	

Do you anticipate or have a change in patient volume?  Yes  No

<i>Patient Type</i>	<i>Reason</i>
Inpatient	
Outpatient	
ED	
Home Care	
Renal Dialysis	
Ambulatory Care	
Mental Health	
Substance Abuse	
Other	

**Contact Information:**

**HMCC Duty Officer:** Pager: (413) 773-1502  
 Email: hmcc@frcog.org  
 Main fax number – (413) 774-3169

**OPEM Duty Officer:** Pager 617-339-8351

**Gail Bienvenue:** Work Phone: 413-586-7525  
 Cell: 617-438-1466