

MED COMM – PATIENT ROUTING SHEET

Incident Name: _____ Date: _____ Time: _____.

HOSPITAL	First wave number of patients			Number of patients sent			Number of patients sent			Number of patients sent		
	I	D	M	I	D	M	I	D	M	I	D	M
KAISER SAN RAFAEL	2	3	6									
MARINHEALTH HOSPITAL	3	4	8									
NOVATO COMM. HOSPITAL	1	2	6									
Petaluma Valley* (707)778-2676	1	2										
SR Memorial* (707) 525-5207	2	3										
Sutter Santa Rosa* (707) 576-4040	1	2										
Kaiser Santa Rosa (707) 571-4800	1	2										
Sonoma Valley (707) 935-5100	1	2										
Queen of the Valley* (707) 257-4014	1	3										
Kaiser Vallejo (707) 651-4910												
Van Ness – CPMC	2	4	6									
ZSFG Trauma Center	10	4	6									
UCSF Parnassus	2	4	6									
Van Ness – CPMC	2	4	6									
SF Kaiser	2	4	6									
St. Francis Memorial	2	4	6									
Bernal - CPMC	2	4	6									
St. Mary's Medical Center	2	4	6									
Davies - CPMC	2	4	6									
<i>(pediatric preferred)</i> UCSF- Mission Bay*	2	4	6									

*Denotes Hospitals with Helipads

TRANSPORTATION GROUP SUPERVISOR - WORKSHEET
Marin County Emergency Medical Services System

Incident Name:

Date:

Time:

NUMBER OF VICTIMS REPORTED BY CATEGORY						AMBULANCES ATTACHED			
TIME	Immediate	Delayed	Minor	Deceased	TOTALS				

Position	Name
Medical Group Supervisor	
Patient Transportation Group Supervisor	
Ground Ambulance Coordinator	
Air Ambulance Coordinator	
Medical Communications Coordinator	

CRITICAL ACTIONS CHECKLIST
<p>These items are provided as reminders and do not replace standard ICS actions related to each position.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Move on-scene ambulances to appropriate MERA talk groups <input type="checkbox"/> Ascertain system 911 ambulance availability as soon as possible <input type="checkbox"/> Prepare information for relay by County Communications (send HAZMAT/decon. information, etc.) <input type="checkbox"/> Receive Assignment when on-scene (order additional ambulance resources after receiving assignment and if authorized by the IC or designee) <input type="checkbox"/> Consider recommending request for MCI Cache(s) (via the IC)

MEDICAL PLAN	1. INCIDENT NAME	2. DATE PREPARED	3. TIME PREPARED	4. OPERATIONAL PERIOD					
	5. INCIDENT MEDICAL AID STATIONS								
MEDICAL AID STATIONS	LOCATION			PARAMEDICS					
				YES	NO				
6. TRANSPORTATION									
A. AMBULANCE SERVICE									
NAME	ADDRESS		PHONE		PARAMEDICS				
					YES	NO			
B. INCIDENT AMBULANCES									
NAME	ADDRESS		PHONE		PARAMEDICS				
					YES	NO			
7. HOSPITALS									
NAME	ADDRESS		TRAVEL TIME		PHONE	HELIPAD		BURN CENTER	
			AIR	GROUND		YES	NO	YES	NO
8. MEDICAL EMERGENCY PROCEDURES									
ICS 206 (SEMS 2003)		9. PREPARED BY (MEDICAL UNIT LEADER)				10. REVIEWED BY (SAFETY OFFICER)			