ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to request pediatric medical resources and identify availability of resources at a health care facility.

Instructions: When the annex is activated, this form will be utilized by **all** stakeholders (e.g. health care facilities, LHDs, IDPH, PCMS) to communicate necessary information about the incident, annex activation, and pediatric patient transfer resource needs/requests. For pediatric care equipment needs/requests, complete the ICS 213RR form and submit it through the Request for Medical Resources Process as outlined in the IDPH ESF-8 Plan.

INCIDENT NAME:			
DATE/TIME PREPARED	**DATE/TIME RECEIVED**	**OPERATIONAL PERIOD**	**RECEIVED VIA** ☐Phone ☐Radio ☐Fax ☐Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** ☐YES ☐NO If YES, *include detailed sending information* below **REPLY TO: ☐Phone ☐Radio ☐Fax** **Other (List number)**	
PRIORITY: □ Urgent/High □ Non-urgent/Medium □ Informational/Low			
DATE/TIME PHEOC ACTIVATED		**REASON FOR PHEOC ACTIVATION**	
DATE/TIME ANNEX ACTIVATED		**REASON FOR ANNEX ACTIVATION**	
ACTIVATION LEVEL □☐Local ☐Regional ☐State			
DATE/TIME PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATED		**REASON FOR PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATION**	
CURRENT INCIDENT INFORMATION			

CURRENT NUMBER OF PEDIATRIC/NEONATAL BED NEEDS

(The purpose of this section is to identify the number of pediatric/neonatal patients and what type of health care facility is needed for their care when the Annex is activated. These categories are for interfacility transfers only, not EMS scene transports. Enter the total number of patients for each triage category in the corresponding boxes below. In the *Pediatric Patient Placement Information* section on page 2 of this form, provide more specific information about the individual patients (tracking number, gender, and age). For more information, see Pediatric and Neonatal Surge Annex, Attachment 10: Pediatric Triage Guidelines.

	TRIAGE CATEGORY					
	CRITICAL CARE (PICU/NICU)	**INTERMEDIATE CARE (Pediatric/Neonatal Intermediate Care)**		**GENERAL CARE (Pediatric/neonatal general medical care)**		
	CATEGORY 1 HOSPITALS	**CATEGORY 2 HOSPITALS**	**CATEGORY 4 HOSPITALS**	**CATEGORY 2 HOSPITALS**	**CATEGORY 3 HOSPITALS**	**CATEGORY 4 HOSPITALS**
NUMBER OF PATIENTS						

Definitions:

- Category 1: Specialty centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU}) able to provide complex pediatric care to ages 0 through 15 years (includes Pediatric Critical Care Centers {PCCC})
- Category 2: Community hospitals with some pediatric services (includes Emergency Departments Approved for Pediatrics {EDAP}) and accepts 0-12 year-old patients
- Category 3: Community hospitals with no pediatric/neonatal services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 12 years old and older patients
- Category 4: Community hospitals with Level I, II and/or II-E (II+) nurseries, but no other pediatric services and accepts 0-1 year-old patients (can include Standby Emergency Departments Approved for Pediatrics {SEDP})

ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

REQUIRED/REQUESTED ACTIONS AT THIS TIME

PEDIATRIC/NEONATAL PATIENT PLACEMENT INFORMATION

The transferring health care facilities should complete this section for each patient that requires transfer/placement at another health care facility when submitting a request to the PCMS. Do not include detailed information about the patient's medical condition or treatment. Once a receiving facility has been identified, the PCMS will complete the last column and send this information back to the transferring facility.

To be Completed by the Transferring Health Care Facility				To be Completed by the PCMS
Patient Tracking Number (assigned by initial health care facility)	**Triage Category**	**Gender**	**Age**	**Receiving Health Care Facility Name** **Receiving Health Care Facility Address**

SEND REPLY TO: ☐ **Phone** ☐ **Radio** ☐ **Fax**
Other (List number):

PREPARED BY

RECEIVED BY	**TIME RECEIVED**	**FORWARD TO**

COMMENTS

FACILITY NAME/LOCATION

*Adapted from HICS 213 Form