|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INCIDENT NAME** Click here to enter text. | | | | |
| **DATE/TIME PREPARED**  Click here to enter a date.  Click here to enter time | **DATE/TIME RECEIVED**  Click here to enter a date.  Click here to enter time | | **OPERATIONAL PERIOD**  Click here to enter text. | **RECEIVED VIA**  Choose an item.  Other Click here to enter text. |
| **FROM (SENDER)**  Click here to enter text. | **TO (RECEIVER)**  Click here to enter text. | | **REPLY/ACTION REQUIRED?** Choose an item.  If YES, *include detailed sending information* below | |
| **REPLY TO:** Choose an item. Other  List contact information: Click here to enter text. | |
| **PRIORITY** Choose an item. | | | | |
| **DATE/TIME PHEOC ACTIVATED**  Click here to enter a date.  Click here to enter a time. | | **REASON FOR PHEOC ACTIVATION**  Click here to enter text. | | |
| **DATE/TIME ANNEX ACTIVATED**  Click here to enter a date.  Click here to enter a time. | | **REASON FOR ANNEX ACTIVATION**  Click here to enter text. | | |
| **ACTIVATION LEVEL**  Choose an item. | | **STATE BURN COORDINATION CENTER (SBCC) NAME**  Choose an item. | | |
| **DATE/TIME SBCC ACTIVATED**  Click here to enter a date.  Click here to enter a time. | | **REASON FOR SBCC ACTIVATION**  Click here to enter text. | | |
| **CURRENT INCIDENT INFORMATION**  Click here to enter text. | | | | |

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| **CURRENT NUMBER OF BURN PATIENT PLACEMENT NEEDS**  The purpose of this section is to identify the number of burn patients and what type of health care facility is needed for their care during a burn MCI. 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 *Burn 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 Burn Surge Annex, Attachment 15: Hospital Burn Triage Guidelines: Mass Casualty Burn Center Referral Criteria. | | | | | | | | | | | |
|  | **TRIAGE CATEGORY** | | | | | | | | | | |
| **CATEGORY 1** | | **CATEGORY 2** | | | **CATEGORY 3** | | | | **CATEGORY 4** | **CATEGORY 5** |
| **HOSPITAL WITH BURN CAPABILITIES** | | **TRAUMA/NON BURN HOSPITAL** | | | **ANY ACUTE CARE HOSPITAL WITH AN ICU** | | | | **NON-TRAUMA/ NON-BURN HOSPITAL** | **ANY ACUTE CARE HOSPITAL** |
| **NUMBER OF PATIENTS** | Click here to enter a number. | | Click here to enter a number. | | | Click here to enter a number. | | | | Click here to enter a number. | Click here to enter a number. |
| **REQUIRED/REQUESTED ACTIONS AT THIS TIME**  Click here to enter text. | | | | | | | | | | | |
| **BURN PATIENT PLACEMENT INFORMATION**  The transferring hospitals should complete this section for each patient that requires transfer/placement at another hospital when submitting a request to the SBCC. Do not include detailed information about the patient’s medical condition or treatment. Once a receiving hospital has been identified, the SBCC will complete the last column and send this information back to the transferring hospital. | | | | | | | | | | | |
| *To be Completed by the Transferring Hospital* | | | | | | | | | *To be Completed by the SBCC* | | |
| **Patient Tracking Number** (assigned by initial health care facility) | | **Triage Category**  **(Category 1-5)** | | | **Gender** | | **Age** | | **Receiving Hospital Name** | | |
| **Receiving Hospital Address** | | |
| Click here to enter a number. | | Click here to enter Category. | | | Choose an item. | | Enter age | | Click here to enter text. | | |
| Click here to enter text. | | |
| Click here to enter a number. | | Click here to enter Category. | | | Choose an item. | | Enter age | | Click here to enter text. | | |
| Click here to enter text. | | |
| Click here to enter a number. | | Click here to enter Category. | | | Choose an item. | | Enter age | | Click here to enter text. | | |
| Click here to enter text. | | |
| Click here to enter a number. | | Click here to enter Category. | | | Choose an item. | | Enter age | | Click here to enter text. | | |
| Click here to enter text. | | |
| **SEND REPLY TO:** Choose an item. Other  List contact information Click here to enter text. | | | | | | | | | | | |
| **RECEIVED BY**  Click here to enter text. | | | | **TIME RECEIVED**  Click here to enter a time. | | | | **FORWARD TO**  Click here to enter text. | | | |
| **COMMENTS**  Click here to enter text. | | | | | | | | | | | |
| **FACILITY NAME/LOCATION**  Click here to enter text. | | | | | | | | | | | |