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| **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.[ ]  OtherList 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. |