

Temporary Medical Treatment Station Selection Tool

Date: _____

Please provide as much information as possible. If possible, also provide a map of the local area, a patient flow diagram, blueprints, or drawings of the patient care area detailing electrical outlets, phone jacks, toilets, etc.

RHCC Region: _____

RHCC Coordinator: _____

Site Name: _____

Site Address: _____

County: _____ GPS Coordinates: _____

Closest Major Intersection: _____

Site Category (i.e., College Campus, Airport, etc.): _____

What is site used for _____

Is site designated for use by any other agency (Local EMA, Red Cross) _____

Site Contact Information: _____

Contact Name: _____ Contact Phone #1: _____

Contact email: _____

Local Health Department: _____

Contact Name: _____ Contact Phone #1: _____

Contact email: _____

Additional Contacts

RHCC Contact Name: _____ Contact Phone #1: _____

RHCC Contact email: _____ Contact Phone #2: _____

Local EMA Region: _____

EMA Contact Name: _____ Contact Phone #1: _____

EMA Contact email _____

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Public Safety

Law Enforcement Jurisdictions: A. _____ B. _____

A. Primary Contact Name: _____ Contact Phone _____

A. Contact email: _____

B. Primary Contact Name: _____ Contact Phone _____

B. Contact email: _____

State Police Jurisdiction: _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____

Local Fire Department(s): _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Second Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Local EMS Resources: _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Second Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Local Private Ambulance Resources:

A. _____ B. _____

A. Primary Contact Name: _____ Contact Phone #1: _____

A. Contact email: _____ Contact Phone #2: _____

B. Primary Contact Name: _____ Contact Phone #1: _____

B. Contact email: _____ Contact Phone #2: _____

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Health Services:

Local Hospitals: (name and address)

1. _____ Distance: _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Second Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Hospital info (check all that apply):

ED Peds Level: SEDP EDAP PCCC

Trauma Level: Non Trauma Center Trauma Level II Trauma Level I

EMS Hospital Designation: Resource Participating Associate

2. _____ Distance: _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Second Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Hospital info (check all that apply):

ED Peds Level: SEDP EDAP PCCC

Trauma Level: Non Trauma Center Trauma Level II Trauma Level I

EMS Hospital Designation: Resource Participating Associate

Closest Pediatric Intensive Care Unit: (name and address)

_____ Distance: _____

Primary Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

Second Contact Name: _____ Contact Phone #1: _____

Contact email: _____ Contact Phone #2: _____

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Regional Burn Center/Unit: (name and address)

_____ Distance: _____

Primary Contact Name: _____ Contact Phone: _____

Contact email: _____

Second Contact Name: _____ Contact Phone: _____

Contact email: _____

Other Local Health Care Resources:

(Nearby surgi-centers, clinics, dialysis centers, orthopedics, mental health, diagnostics, x-rays, etc.)

Local Contacts (Please provide name, number and address if possible)

Local Physician: _____

Local Dentist: _____

Local Pediatrician: _____

Local Orthopedist: _____

Home Health/Hospice _____

Durable Medical Goods Provider _____

Medical Gas Provider _____

Local Pharmacy: _____

Big Box Store: _____

Hardware Store: _____

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INFRASTRUCTURE

Total Square Footage: _____

(Recommend 20-25,000 square feet for 50-100 Patients)

Is there an existing perimeter (i.e.: fence) _____

Can a secure perimeter be created _____

Is there space that can be designated for pediatric care (lock-down capable) _____

Is there separate space to store pediatric supplies _____

Is there space for palliative/hospice care (removed from the general area) _____

Exterior triage area _____

Access

Number of parking spaces: _____ Expandable _____

Turn-around area for ambulances/trucks/buses/semis _____

Parking area for ambulances/trucks/buses/semis _____

Loading dock _____

Fork lift _____

Separate staging area for "official" vehicles (squad cars, military vehicles) _____

Separate vehicle entrance for staff, ambulances etc. _____

Is parking area well-lit _____ is parking area under video surveillance _____

Does the facility have ramps or other accessible pathways? _____

Area for helicopters to land? _____

Facility

Number of floors: _____

Number of elevators? _____

Number of toilets: _____

Number of handicap-accessible toilets: _____

Number of sinks: _____

Number of showers: _____

Number of handicap-accessible showers: _____

Number of bathtubs: _____

Water supply

Well or municipal. If well, what is the maximum flow available? _____

Hot water supply: __YES __NO

Door size adequate for gurneys/wheelchairs _____

Equipment/supply/storage area available _____

Family sleeping area available _____

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Area for service animal exercise _____
Food supply and prep area available _____
 Number of refrigerators: _____
 Number of freezers: _____
Areas for operational/command set-up _____
Separate staff sleeping quarters _____
Private staff area _____
 Computers available for staff use _____
 WI Fi enabled? _____
 Number of available computers: _____

O2 Available __YES __NO

Securable area for pharmacy _____
Lab specimen handling area _____
Mortuary capacity _____
Does the building have video surveillance _____
Possible external decon area _____
 With exterior running water/runoff containment _____
 With hot and cold water access _____

HVAC Capacity: _____

Utilities

Electrical service provider _____
Circuit breakers or fuses _____ Location: _____
Backup generator available _____ Location: _____
 Size of Generator: _____
 Fuel type for Generator: _____
 If diesel or propane, how long will tank run generator _____

Please check what the back-up generator provides

Air conditioning _____
Heat _____
Other means of ventilation _____
Adequate lighting - interior _____
Adequate lighting – exterior _____
Number of electrical outlets _____

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Communications

Number of phones: _____

Number of phone lines: _____

Number of phone jacks: _____

Intercom/loudspeaker system _____

Wired Internet access _____

Wireless (Wi-Fi) Internet access _____

COMMENTS:

Other Features

Food prep area _____

Refrigerators-Freezers _____

Laundry facilities on premises _____

Floor coverings: _____

Existing furniture: _____

Can all doors be locked? _____

Is there an existing service for Biohazard waste storage _____

Contact: _____

Are there existing Biohazard waste storage units? _____

Waste storage capacity: _____

Local Resources

Please fill out name, address and contact numbers where applicable.

Rubbish service: _____

Portable toilet service: _____

Water service: _____

Electric service: _____

Gas service: _____

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Red Cross: _____

Salvation Army: _____

Local Chamber
Of Commerce: _____

Senior services: _____

School Bus: _____

Local Transport:
Taxi _____

Local Train Station: _____

Local Airport: _____

Vehicle repair garages: _____

Auto parts Store: _____

Closest Gas Station: _____

Hardware store: _____

Laundry: _____

Lodging: _____

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COMMENTS:

Available Documents:

Please attach all additional documents

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| 1. GIS Picture | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Local Map | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Diagram/Schematic of Facility | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Patient Flow Diagram | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Survey Conducted By:

Name

Email

Phone

Name

Email

Phone

COMMENTS: