

**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.*

<b>RHCC Region:</b> _____
<b>RHCC Coordinator:</b> _____

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)

Estimated Bed Capacity: \_\_\_\_\_

(Recommend accounting for 6 feet between each bed, refer to CDC guidelines for appropriate spacing of beds)

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 \_\_\_\_\_

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- Equipment/supply/storage area available \_\_\_\_\_
- Family sleeping area available \_\_\_\_\_
- 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:

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## 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