

EMAT INCIDENT INFORMATION FORM

Location:	Date:
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CONTACT INFORMATION
(please indicate staff in command of your disaster response system both medical and operational)
Organization/Hospital:
<p>Contact Person/s: _____ Title: _____</p> <p>Phone: Office: _____ Mobile: _____</p> <p>Pager: _____ Fax: _____</p> <p>Contact Person/s: _____ Title: _____</p> <p>Phone: Office: _____ Mobile: _____</p> <p>Pager: _____ Fax: _____</p> <p>Contact Person/s: _____ Title: _____</p> <p>Phone: Office: _____ Mobile: _____</p> <p>Pager: _____ Fax: _____</p>

GENERAL INFORMATION:					
Circle Incident Type :	Disaster – General	MCI	Chemical	Biological/ Infectious Disease	Radiological
Estimated Number of Patients Received and/or Expected:	()			Percentage of Pediatrics:	()
Extra Medical Staff Required within Hospital:	Yes	No			
Numbers and type of Medical Staff Required: Tech.	()	MD	()	RN	()
Number of Patients Requiring Mechanical Ventilation:	()				
Number of Functional Operating Rooms:	()				
Number of General Surgeons Available	()				
Blood Bank Available	Yes	No	Number of units	O pos. ()	O neg. ()
Orthopedic or Neurosurgery Capabilities:	Yes	No			
Additional Medical Equipment Required:	Yes	No			
If yes, please specify:	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>				

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List other agencies that have been notified or are currently involved:

(please document incident commanders from any other agencies working in this disaster response i.e. EMS, Fire, Public Health)

Organization/Hospital: _____

Contact Person/s: _____ Title: _____

Phone: Office: _____ Mobile: _____

Pager: _____ Fax: _____

Organization/Hospital: _____

Contact Person/s: _____ Title: _____

Phone: Office: _____ Mobile: _____

Pager: _____ Fax: _____

Organization/Hospital: _____

Contact Person/s: _____ Title: _____

Phone: Office: _____ Mobile: _____

Pager: _____ Fax: _____

Organization/Hospital: _____

Contact Person/s: _____ Title: _____

Phone: Office: _____ Mobile: _____

Pager: _____ Fax: _____

BIOLOGICAL/INFECTIOUS DISEASE – ADDITIONAL INFORMATION:

Specific Infectious Agent Identified: _____

Negative Pressure Room Available: Yes No # used () # available ()

Current antibiotic / antiviral treatments in use:

