Santa Clara County RACES Radio Routing Slip				
Radio Operator Only:	<sup>1</sup> Origin Msg #:	Destination Msg #:		

This Section to be Completed by Message Author/Cro				eator: ( <u>Underlined=Req</u> u			derlined=Required)	
<sup>2</sup> Date: <sup>3</sup> Time (24hr): <sup>4</sup> Handling:		Olmmediate (ASAP) OPrio		OPriority (<1 hr)	ORoutine (<2 hr)			
	⁵ <u>IC</u>	S Position:			<sup>9</sup> ICS Position:			
Т	6 <u>L</u> c	ocation:			R	10 Location:		
0	<sup>7</sup> N	ame:				<sup>11</sup> Name:		
	8 C	ontact Info:			M	12 Contact Info:		
Fori	m: <sup>13</sup> <u>Type</u> :			<sup>14</sup> To	ppic:			

#### **Instructions for Message Author/Creator:**

- 1. Complete section above, surrounded by BOLD line (see instructions on back)
- 2. Fill in all Required fields
- 3. Attach to the front of a form to be sent via radio
- 4. Deliver to radio operator for transmission

Radio Operator Only:							
Relay:	Rcvd:			Sent:			
Name:		Call Sign:		Date:	Time (24hr):		

## **Instructions: Radio Routing Slip**

**Purpose:** The SCCo RACES Radio Routing Slip is used to add the necessary radio handling information to an existing form that does not already have these fields.

#### **Instructions for Message Authors/Creators:**

Field	Instructions
Date	Required. Enter the date created.
Time	Required. Enter the time created. Use 24-hour time.
Handling	Required. Select one. Messages are sent in priority order and as soon as possible. Indicated
	times are approximate maximum wait times if radio net is busy.
TO / FROM	If needed, radio operator can suggest most appropriate TO position and location.
ICS Position	Required. Enter the ICS position name.
Location	Required. Enter the location (such as name of EOC, hospital, base, command post, shelter,).
Name	Optional. Enter only if the message is to/from a specific individual.
Contact Info	Optional. Enter a phone number, frequency or other info that may help reach the person or
	position.
Form	This info will aid in matching the associated form if this routing slip becomes separated.
Туре	Required. Enter the type of the attached form. Example: "213RR"
Topic	Required. Enter the topic/subject of the attached form. Example: "Barricades"

### **Instructions for Radio Operators:**

**Important:** Write the Origin message number on the top right of the attached form, in case it becomes separated. Staple this routing slip to the front of the form being handled. Fields are numbered in the order they should be sent over the air.

Field	Instructions
Origin Msg #	Required. Enter the message number of the original sending station.
Destination Msg #	Required. Enter the message number of the ultimate destination station.
Relay	When relaying: Enter a call sign and/or time, or other useful mark or info, to indicate status.
Name	Required. Enter the first initial and last name of the radio operator that handled the message.
Call Sign	Required. Enter the call sign of the radio operator that handled the message.
Date	Required. Enter the date the message was sent/received.
Time	Required. Enter the time the message was sent/received. Use 24-hour time.

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# **DEOC-9** ALLIED HEALTH STATUS REPORT SHORT FORM

Other Phone, Fax, Cell Phone, Radio:  Incident Name and Date:  CHECK ADDITIONAL ATTACHMENTS PROVIDED Yes/No CREEN-FULLY FUNCTIONAL DECOMPTION AND CREEN FORMS NHIGS/ICS STATUS REPORT FORMS NHIGS/ICS STA	FACILITY NAME:			FACILTY TYPE		DATE: TIME:				
FACILITY STATUS  CHECK ONE CHECK ADDITIONAL ATTACHMENTS PROVIDED  Yes/No. GREEN: FULLY FUNCTIONAL  NHICS/ICS ORGANIZATION CHART  DEOC-9A RESOURCE REQUEST FORMS NHICS/ICS STATUS REPORT FORM - STANDARD  NHICS/ICS STATUS REPORT FORM - STANDARD  NHICS/ICS STATUS REPORT FORM - STANDARD  NHICS/ICS SINCIDENT ACTION PLAN  PHONE/COMMUNICATIONS DIRECTORY  GENERAL SUMMARY OF SITUATION/CONDITIONS  FACILITY EOC MAIN CONTACT FAX  GENERAL SUMMARY OF SITUATION/CONDITIONS  FACILITY LINISON OFFICER NAME: LIAISON TO PUBLIC HEALTH BRANCH  FACILITY INFORMATION OFFICER CONTACT EMAIL  IF FACILITY INFORMATION OFFICER CONTACT EMAIL  IF FACILITY INFORMATION OFFICER CONTACT EMAIL  FACILITY INFORMATION OFFICER CONTACT EMAIL  FACILITY CONTACT FUNDER  FACILITY CONTACT NUMBER  FACILITY CONTACT NUMBER  FACILITY CONTACT NUMBER  FACILITY CONTACT NUMBER  FACILITY PATIENTS TO EVACUATE  ASSISTED LIVING  SUB-ACUTE  FACILITY PATIENTS TO EVACUATE  ALZEMERS/DIMENTIA  PEDATRIC-SUB ACUTE  *SURGE number: # of beds in addition to vaccant available be  BAYLILABLE RESOURCES  CONTACTED FOR MAIN CONTACT NUMBER  FACILITY PATIENTS TRANSFERED OUT OF COUNTY  OTHER FACILITY PATIENT CARE INFORMATION  DEOC/EOC/DUTY CHIEF USE  *SURGE NUMBER: # of beds in addition to vaccant available be  AVAILABLE RESOURCES  SOURCES  AVAILABLE RESOURCES  SOURCES  SOURC	Contact Name:			Phone #	Fax #					
RED- LIMITED SERVICES  DEOC-9A RESOURCE REQUEST FORMS  BLACK- IMPAIRED/CLOSED  STANDARD  NHICS/ICS STATUS REPORT FORM - STANDARD  NHICS/ICS INCIDENT ACTION PLAN  PHONE/COMMUNICATIONS DIRECTORY  GENERAL SUMMARY OF SITUATION/CONDITIONS  FACILITY LUISON OFFICER NAME: LUISON TO PAGILITY LUISON OFFICER NAME  FACILITY INFORMATION OFFICER CONTACT NUMBER  FACILITY INFORMATION OFFICER CONTACT EMAIL  IF FACILITY EOC IS NOT ACTIVATED, WHO SHOULD BE CONTACTED FOR QUESTIONS/REQUESTS  SKILLED NURSING  FACILITY CONTACT NUMBER  FACILITY POTIENT FLOW INFORMATION  TOTAL  SUB-ACUTE  ALZEIMERS/DIMENTIA  LIZEIMERS/DIMENTIA  PEDIATRIC-SUB ACUTE  FACILITY PATIENTS TO EVACUATE  ALZEIMERS/DIMENTIA  PEDIATRIC-SUB ACUTE  PSYCHIATRIC  JULIANS SUB-CUTE  AVAILABLE RESOURCE  SURGICAL  AVAILABLE RESOURCE  S	Other Phone, Fax, Cell Phone, Radio:			Incident Name and Date:						
RED-LIMITED SERVICES  BLACK-IMPAIRED/ICLOSED  BLACK-IMPAIRED/ICLOSED  STANDARD  NHICS/ICS STATUS REPORT FORM - STANDARD  NHICS/ICS SINCIDENT ACTION PLAN  PHONE/COMMUNICATIONS DIRECTORY  FACILITY LIAISON OFFICER NAME: LIAISON TO PUBLIC HEALTH-MEDICAL HEALTH-BRANCH PACILITY LIAISON CONTACT NUMBER  FACILITY INFORMATION OFFICER NAME FACILITY INFORMATION OFFICER CONTACT NUMBER  FACILITY INFORMATION OFFICER CONTACT NUMBER  FACILITY ON ACTIVATED, WHO SHOULD BE CONTACTED FOR QUESTIONS/REQUESTS  SKILLED NURSING  SKILLED NURSING  ASSISTED LIVING  FACILITY PATIENTS TO EVACUATE  ALZEIMERS/DIMENTIA  LIZEMERS/DIMENTIA  PEDIATRIC-SUB ACUTE  ALZEIMERS/DIMENTIA  DEOC/EOC/DUTY CHIEF USE  AVAILABLE RESOURCE  **SURFIGE SUB ACUTE  ALZEIMERS/DIMENTIA  **SURFIGE SUB ACUTE  ALZEIMERS/DIMENTIA  BLACK-IMPAIRS SURFACE  SURGICAL  **SURFIGE SURGION OF COUNTY  PSYCHATRIC  DIALYSIS  SURGICAL  **SURFIGE COUNTACT SITUATION OF COUNTY  DIALYSIS  SURGICAL  **SURFIGURATIVE OF COUNTY  DIALYSIS  **SURFIGURATIVE OF COUNTY  DIALYSIS  **SURFIGURATIVE OF COUNTY  DIALYSIS  **SURFIGURATIVE OF COUNTY  DIALYSIS  **SURFIGURATIVE OF COUNTY  DIAL	FACILITY STATUS		CHECK ONE	CHECK ADDITIONAL ATTACH	MENTS PRO	VIDED		Yes/	No	
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				DIALYSIS						
CLINIC				SURGICAL						
OLIVIO DE LA CONTRACTOR				CLINIC						
HOMEHEALTH HOMEHEALTH				HOMEHEALTH						
ADULT DAY CENTER				ADULT DAY CENTER						

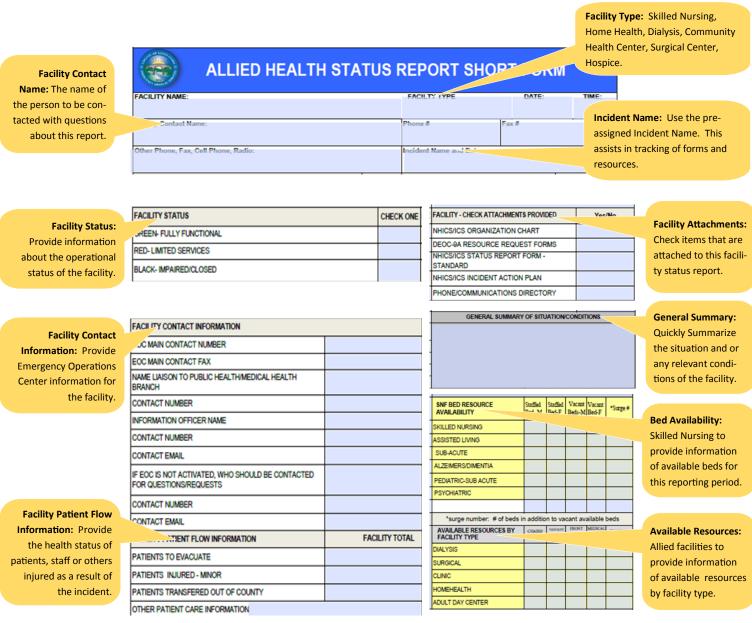
Please follow instructions received from email/phone/CAHAN on how to submit this form. If telephones/fax are not working, use alternate means of communication (radio, messenger, etc.) Use the RESOURCE REQUEST FORM to request resources.

ALLIED HEALTH STATUS REPORT FORM – Revised February 2018 Department Operations Center Form 9 (DEOC-9)



# COMPLETING the DEOC 9: ALLIED HEALTH STATUS SHORT FORM

**PURPOSE:** The DEOC-9 Form is used for reporting information on significant incidents. It is not intended for every incident, as most incidents are short in duration and do not require scarce resources, significant mutual aid, or additional support and attention. The DEOC-9 form contains basic information elements needed to support situational awareness and decision-making at all levels.



Accurate and timely completion of the DEOC-9 assists in maintaining good situational awareness of the incident, assessment of resources, resource allocation, and timely request for regional mutual aid. Please keep this document in the Communications Section of the Emergency Operations Manual for training purposes.