

## FORM 2. RESOURCE REQUEST FORM USED BY MHOAC PROGRAMS

Instructions: MHOAC Program should submit completed form to RDMHC Program.

Name of Requesting Operational Area	Date	Time (24 hr. format)
Name of person making request (First/Last)	Title of person making request	
Telephone contact numbers (office, cell, fax, other)	Email address	
24-hour POC (Name)	24-hour POC contact numbers	
<b>Location Type</b> <input type="checkbox"/> Evacuating Hospital <input type="checkbox"/> Field Treatment Site <input type="checkbox"/> Evacuating SNF <input type="checkbox"/> Casualty Collection Point	<b>Location Address</b>	

<b>Section 1. Patient Transport</b>		
<b>GROUND AMBULANCE Patient Types</b>	<b># of Patients/Passengers</b>	
# of stretcher patients needing ALS		
# of stretcher patients needing BLS		
# of bariatric patients (pt. weighs > 400lbs., extra wide stretcher). All bariatric units are ALS.		
<b>PARATRANSIT Passenger Types</b>		
# of passengers that are <b>ambulatory, do not require assistance</b> and can ride in a van or bus		
# of passengers that are <b>"ambulatory-with-assistance"</b> that can ride in a van or bus with assistance but do not require a wheelchair or stretcher		
# of <b>non-ambulatory passengers that may need a wheelchair</b> but do not require stretcher		
# of <b>caregivers</b> that will be provided to accompany paratransit passengers		
<b>AIR AMBULANCE Patient Types</b> (adult/child and neonatal)	<b>ADULT and CHILD</b>	<b>NEONATE</b>
# of patients requiring transportation by helicopter air ambulance		
# of patients requiring transportation by fixed-wing air ambulance		
<b>Additional EMS Personnel Not Assigned to Requested AMR Ambulance Crews</b>		
EMT-Basic / EMT (additional EMTs who are not assigned to ambulances)		
EMT-Paramedic / Paramedic (additional Paramedics who are not assigned to ambulances)		
EMS Communications Support Team Member		
EMS Field Operations Team Member / EMS Incident Management Team Member (IMT)		

Section 2. EMS Delivery Location													
Delivery Point-of-Contact (Name):					24 Hour Phone #:					Secondary Contact #:			
DELIVERY LOCATION					AMBULANCES					PERSONNEL			
County	Site Name	Address	City	Zip	ALS Ground	BLS Ground	Bari Ground	Fixed Wing	Rotary Wing	EMT Basic	EMT-P	EMS Comms	EMS Field Ops
Section 3. Bed Types Needed													
Patient Type	Bed Type	#											
<u>Adult:</u>	Med/Surgical	<input type="checkbox"/>											
	OB/L&D	<input type="checkbox"/>											
	Psychiatric	<input type="checkbox"/>											
	Critical: Burn	<input type="checkbox"/>											
	Critical: ICU	<input type="checkbox"/>											
	Critical: CCU	<input type="checkbox"/>											
	Critical: Trauma	<input type="checkbox"/>											
<u>Pediatric:</u>	Ped Med/Surgical	<input type="checkbox"/>											
	PICU	<input type="checkbox"/>											
	NICU	<input type="checkbox"/>											