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| Medical and Health Resource Request (PROVIDER to Trinity County MHOAC) | | | | |
| **1. Incident Name:** | **2a. DATE:** | | **2b. TIME:** | **2c. Request Number:** (Assigned by Requesting Entity) |
| **3. Requestor:** | | | | |
| 3. a. Name:  3. b. Agency:  3. c. Position:  3. d. Phone:  3. e. Email: | | | | |
| **4. Describe Mission/Tasks:** | | | | |
| **5. ORDER SHEET(s) ATTACHED:**  SUPPLIES EQUIPMENT MEDICATIONS PERSONNEL | | | | |
| **6. ADDITIONAL CONSIDERATIONS:**  SUGGESTED SOURCE(S) OF SUPPLY: SUITABLE SUBSTITUTE:  SPECIAL DELIVERY COMMENT(S):  PERSONNEL: | |  | | |
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| CHECK IF LODGING AND MEAL ARRANGEMENTS HAVE/WILL BE ARRANGED BY REQUESTOR. | | |
| 7.  THE RESOURCE NEED IS IMMEDIATE AND SIGNIFICANT (OR ANTICIPATED TO BE SO).  THE SUPPLY OF THE REQUESTED RESOURCE HAS BEEN EXHAUSTED, OR EXHAUSTION IS IMMINENT.  THE RESOURCE OR AN ACCEPTABLE ALTERNATIVE IS UNAVAILABLE FROM INTERNAL, CORPORATE SUPPLY CHAIN, OTHER COMMERCIAL VENDOR, OR EXISTING AGREEMENTS. RELEVANT PAYMENT/REIMBURSEMENT ISSUES HAVE BEEN ADDRESSED. | | | | |
| 8. COMMAND/MANAGEMENT REVIEW: Name, Position, & Signature: **(Signing indicates the above statements have been verified and the request has been approved.)**  **NAME: POSITION: SIGNATURE:** | | | | |

Send completed form to the Medical and Health Operational Area Coordinator (MHOAC) at: (530) 623-1297 Fax

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| **5. ORDER**  SUPPLY EQUIPMENT MEDICATIONS PERSONNEL OTHER: | | | | | | | DELIVERY INFO. | |
| **Line #** | **Priority\*** | **DETAILED SPECIFIC ITEM DESCRIPTION: Supplies: characteristics, brand, specs, etc.**  **Rx: Drug Name, Dosage Form, UNIT OF USE PACKAGE, etc.**  **Personnel: experience, licensure, etc.** | **Kind Supplies: Product class (bx, cs, ea, etc.)**  **Rx: Strength Personnel: Specialty** | **Type Supplies: # per product class**  **Rx: Unit, concentr. Personnel: certs, etc.** | **Quantity"" Requested** | **Expected Duration of Use:** | Delivery  Location | Delivery Point of Contact: Name, Phone, Fax, Email |
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| **6. Suggested Source(s) of Supply; Suitable Substitute(s); Special Delivery Comment(s):** | | | | | | |  | |

**\*PRIORITY: (E)mergent <12 hour (RIMS:FLASH/HIGH), (U)rgent >12 hour (RIMS: MEDIUM) or (S)ustainment (RIMS: LOW)**

**\*\*QUANTITY: Based upon a unit of EACH; Pharmaceuticals are based upon a single regimen of the requested unit.**

Send completed form to your local MHOAC.