13-0104C – Receiving Facility MCI Evaluation Form

AUTHORITY:
Health and Safety Code Division 2.5, California Code of Regulations, Title 22, Division 9

PLEASE COMPLETE THE FOLLOWING FOR ALL MCI'S AND FULL-SCALE EXERCISES
(Fax completed form to 530-229-3984 or email: mail@norcalems.org)

NAME OF RECEIVING FACILITY	
NAME OF PERSON COMPLETING FORM	
TITLE	
PHONE	
EMAIL	

Incident Information: ❒ Drill ❒ Actual Incident:
❒ Lassen County ❒ Modoc County ❒ Plumas County ❒ Sierra County ❒ Trinity County
Incident date: _____ Incident time: _____ Incident name: _____
First "MCI Alert" received from: _____ Initial alert time: _____
Incident location: _____

Were you given adequate information regarding the event?	❒ YES	❒ N0
Any issues encountered with "MCI Alert" and/or Incident?	❒ YES	❒ N0
Did the Control Facility provide adequate updates?	❒ YES	❒ N0
Any issues identified with EMResource / bed polling?	❒ YES	❒ N0
Any issues identified with communications?	❒ YES	❒ N0
Were you given the following information about your patients? Transport Unit ❒ YES ❒ N0 ETA ❒ YES ❒ N0 Injury/Illness ❒ YES ❒ N0		
Were the patient conditions consistent with triage category?	❒ YES	❒ N0
Were triage tag numbers entered into the patient's ED record for tracking purposes?	❒ YES	❒ N0
If issues identified above, please provide narrative as well as any comments, suggestions or observations (attach additional documentation if needed):		