Auxiliary Communications
Expanded Medical/Health Status Report
Facility to Operational Area

Form: CoCo ACS-2-HE Rev. 0, 9/2001

Section I.

RIMS Codes
H-1 Facility Name: ___________________________ Originator: ___________________________

H-2 Date/Time: _______________________________

H-3 Available Contact Methods:

☐ Phone # ____________________________

☐ FAX # ____________________________

☐ Radio Frequency ____________________________

☐ Email Address ____________________________

Section II. Status of Hospital (See definitions on reverse)

RIMS Code
SR-8.b Non Functional

SR-8.c Partially Functional

SR-8.d Fully Functional

Section III. Bed Availability

RIMS Codes
RA 23 & 25 Unoccupied Beds Staffed and Available

RA 31 Total Number of Medical & Surgical

RA 31 Total Number Critical Care

Note: The 8-hour and 24-hour numbers are independent numbers and not cumulative totals, OB and pediatric beds are included for Medical/Surgical Patients.

Section IV. Estimated Casualties

RIMS Code
SR-7.a Major # ___________________________

SR-7.b Minor # ___________________________

Section V. Medical/Health Critical Issues and Actions Taken (Brief Summary of Most Critical)

RIMS Codes
SR-19 ____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Section VI. Mutual Aid Needs (Attach additional sheets if necessary)

RIMS Code
SR-10.a Medical Personnel: ___________________________

SR-10.b Medical Supplies: ___________________________

RIMS Code
SR-10.c Medical Transport: ___________________________

☐ Additional Sheets Attached

Section VII. Information Source(s)

Communicated by: ___________________________ Call Sign: ___________ Date and Time: ___________

Received by: ___________________________ Call Sign: ___________ Date and Time: ___________