

ADULT TRAUMA¹ & (MEDICAL)

Hospital	Immediate Red	Delayed Yellow	Minor Green
UC Davis Medical Center (Level I)	5 (5)	4 (4)	8 (8)
Kaiser South Sacramento (Level II)	1 (2)	2 (2)	5 (5)
Mercy San Juan (Level II)	2 (2)	4 (4)	5 (5)
Sutter Roseville (Level II)	1 (2)	2 (2)	5 (5)
Marshal (Level III)	1 (2)	2 (2)	5 (5)
Methodist	0 (1)	3 (3)	6 (6)
Sutter Sacramento	0 (1)	3 (3)	6 (6)
Mercy General	0 (1)	3 (3)	6 (6)
Kaiser North (Morse)	0 (1)	3 (3)	6 (6)
Mercy Folsom	0 (1)	3 (3)	6 (6)
VA	0 (1)	3 (3)	6 (6)
Kaiser Roseville	0 (1)	3 (3)	6 (6)
Woodland Memorial	0 (1)	1 (1)	6 (6)
TOTAL	10 (21)	36 (36)	76 (76)

¹Patients who meet SCEMSA Critical Trauma Criteria**PEDIATRIC TRAUMA² & (MEDICAL)**

Hospital	Immediate Red	Delayed Yellow	Minor Green
UC Davis Medical Center (Level I)	1 st 6 Trauma (6)	1 (1)	2 (2)
Kaiser South Sacramento (Level II)	1 (1)	2 (2)	5 (5)
Mercy San Juan (Level II)	1 (1)	2 (2)	5 (5)
Sutter Roseville (Level II)	1 (1)	2 (2)	5 (5)
Marshal (Level III)	1 (1)	2 (2)	5 (5)
Methodist	0 (1)	2 (2)	5 (5)
Sutter Sacramento	0 (1)	3 (3)	6 (6)
Mercy General	0 (1)	2 (2)	4 (4)
Kaiser North (Morse)	0 (1)	2 (2)	4 (4)
Mercy Folsom	0 (1)	2 (2)	4 (4)
VA	0 (0)	0 (0)	0 (0)
Kaiser Roseville	0 (1)	3 (3)	6 (6)
TOTAL	10 (16)	23 (23)	51 (51)

²Patients who meet SCEMSA Critical Trauma Criteria

Date: _____ Incident name: _____ Med Grp Sup: _____
 Begin: _____ End: _____ Location: _____ Contact #: _____

Pt #	Time	Sex	Age	Immed	Delayed	Minimal	Expectant	Dead	Injury	Triage Tag#	Trauma Triage Criteria	Unit #	Hosp
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
											Y / N		
TOTAL													

DRAFT

MCI FEEDBACK/REPORTING FORM

REPORTING ENTITY

Reporting Agency:	Reporting Person:
Telephone:	Email Address:

INCIDENT INFORMATION (COMPLETE AS APPLICABLE TO YOUR AGENCY'S ROLE)

Incident Date:	Incident Name:
Incident Location:	
Dispatch Time:	First Unit On Scene Time:
First Transport Unit On Scene Time:	Supervisor On Scene Time:
Incident End Time:	

NUMBER & TYPE OF PREHOSPITAL EMS RESOURCES

First Responder Agencies Utilized:			
Ground Amb. Providers Utilized:			
# of Ground Amb. Requested:		# of Ground Amb. Utilized	
HEMS Providers Utilized:			
# of HEMS Aircraft Requested:		# of HEMS Aircraft Utilized:	
Other Transport Resources:			
Incident Commander:	Transportation Unit Leader:		
Triage Unit Leader:	Med. Communications Coord.:		
Treatment Unit Leader:	Were MCI ID Vests Used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were Triage Tags Used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were Pt. Tracking Sheets Used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

NUMBER & TYPE OF PATIENTS				
IMMEDIATE:	DELAYED:	MINIMAL:	EXPECTANT	DECEASED:
# Of Adult Pts:			# Of Pediatric Pts:	
# Of Pts Transported by EMS:			# Of Pts Refusing Transport:	
HOSPITAL INFORMATION				
CF Representative Name:			Initial CF Contact Time:	
Initial MCI Notification Received From				
Number of CF Staff Assigned:			CF Pt Dispersal Officer:	
Receiving Facilities Utilized:				
FEEDBACK AND SUGGESTIONS				