LONG TERM CARE FACILITY *- BED STATUS*

Sample of Bed Status Form used by Wayne County Medical Control Authority to receive an accurate count of available beds within the county

To be filled out by EOC/MCA requesting information:

EVENT: _____

LTCF Evacuation _____ **Other** _____

TYPE OF BEDS: _____ **Specific Type** _____

All Available/Licensed Virtual/Flex ** _____

******Virtual/Flex beds = the maximum number of beds/stretchers your facility can accommodate to provide patient care.

Remainder of form to be filled out by Long Term Care Facilty:

NAME OF Long Term Care Facility _____ **CONTACT PERSON** _____ **Date** _____ **Time** _____

24 HR. CONTACT PERSON'S PHONE # _____ **FAX #** _____

PATIENT CATEGORY	# of Female Beds	# of Male Beds
TOTAL NUMBER OF REGULAR BEDS AVAILABLE		
TOTAL NUMBER OF LOCKED UNIT BEDS AVAILABLE		
TOTAL NUMBER OF VENTILATOR BEDS AVAILABLE		
TOTAL NUMBER OF DIALYSIS BEDS AVAILABLE		
BARIATRIC BEDS (OVER 300 POUNDS)		
TOTAL OF ALL BEDS LISTED ABOVE THAT ARE AVAILABLE		
TOTAL NUMBER OF "VIRTUAL" BEDS -INCLUDE OFF LINE BEDS AND BEDS IN STORAGE THAT YOU HAVE SPACE FOR AND COULD MAKE AVAILABLE TO ACCEPT PATIENTS		
TOTAL NUMBER OF ISOLATION/PRIVATE ROOMS AVAILABLE (COULD BE USED AS MALE OR FEMALE ROOMS OR FOR ISOLATION)		

AVAILABLE EQUIPMENT	# OF UNITS
O2 CONCENTRATORS	
VENTILATORS	
SUCTION MACHINES	
IV PUMPS	
FEEDING TUBE PUMPS	
RESTRAINTS	
RESPIRATORY SUPPLIES	[ ]YES [ ]NO
DIABETIC SUPPLIES	[ ]YES [ ]NO
NUMBER OF AVAILABLE EMERGENCY POWER OUTLETS (CURRENTLY NOT IN USE)	

Fax To:

Requesting Agency Name _____

Requesting Agency Phone _____

Requesting Agency Fax _____