

**Big Country
Regional Trauma Advisory Council
Hospital Needs Assessment Survey
Fiscal Year 2011**

Instructions: in order to plan for grant requests and identify regional priorities for Fiscal 2011, current information is needed from each RAC member organization. Please complete the following questions and mail the information to the Big Country RAC, 6250 Hwy 83/84-Antilley Rd, Abilene, TX 79606 or fax to 325-437-4888.

**ALL FORMS MUST BE RECEIVED NO LATER THAN September 1, 2010.
COMPLETION OF THE ANNUAL NEEDS ASSESSMENT SURVEY IS A REQUIREMENT
FOR MAINTAINING YOUR RAC ELIGIBILITY!**

Members who do not submit an assessment on time will not be eligible for funding in Fiscal 2011 and may forfeit their voter eligibility.

Please type or print your responses. Emergency numbers will be confidential and used only in declared state or local emergencies:

Name of Hospital: _____

Physical Address: _____

Mailing Address: _____

Hospital Administrator: _____

Phone: _____ FAX: _____

Email: _____

Administrator's Emergency Contact Number (24/7): _____

Trauma Coordinator: _____

Phone: _____ FAX: _____

Email: _____

Trauma Coordinator's Emergency Contact Number (24/7) _____

ED Medical Director: _____

Phone: _____ FAX: _____

Ed Medical Director's Emergency Contact Number (34/7) _____

RAC-D Representative: _____

Phone: _____ FAX: _____

Email: _____

RAC-D Representative's Emergency Contact Number (24/7): _____

RAC-D Alternate Representative: _____

Phone: _____ FAX: _____

Email: _____

RAC-D Alternate Representative's Emergency Contact Number (24/7): _____

Tax status of hospital: _____

Phone Number for on-line Medical Control: _____

Radio Frequency for on-line Medical Control: _____

Number of Licensed Hospital Beds: _____

Number of Emergency Room Beds: _____

Number of Intensive Care Beds: _____

Do you have designated ICU beds for Pediatric patients? YES NO

If yes, how many beds are designated for Pediatric patients: _____

Are you a designated Trauma Facility? YES NO

Trauma Designation Level (circle one) I II III IV

If you are not a designated facility, are you seeking trauma designation? YES NO

If yes, what level are you seeking? (circle one) I II III IV

Do you have a Trauma Registry? YES NO

How many trauma patients do you see in your ER in a 12 month period? _____

How many trauma admissions do you have in a 12 month period? _____

What is your average ISS? _____

When considering transfer of a trauma patient, what facility are you most likely to transfer to?

Why? _____

Who provides 24 hour coverage in your ER? (circle one) MD PA NP

How many physicians are certified in ATLS? _____

How many physicians need certification in ATLS? _____

How many nurses are TNCC certified? _____

How many nurses are seeking TNCC certification? _____

How many nurses are ENPC certified? _____

How many nurses are seeking ENPC certification? _____

Please circle the types of services your facility can provide for a trauma patient:
(circle all that apply):

General Surgery

Orthopedic Surgery

Neurosurgery Surgery

Facial Reconstruction

Spine

Neurology

Of the services you circled, do they provide coverage 24 hours per day? YES NO

If no, please explain in detail: _____

Describe in detail any injury prevention programs used in your institution: _____

Describe in detail, issues your facility has identified that would improve trauma care in your facility:

Equipment Needs				
Equipment	#1 Priority	#2 Priority	#3 Priority	Do you have plans to meet these needs?

Educational Needs				
Course Needed	Training Equipment Needed	# Students Needing Training		Do you have plans to meet these needs?

Public Injury Prevention				
Program Needed	Equipment Needed	Supplies Needed	Target Audience	Follow-up

Use the space below to provide details concerning your needs:
