



Community Blood Center
 Community Tissue Services
 Dayton, OH 45402

DISASTER HOSPITAL MEDICAL NEEDS ASSESSMENT

Hospital Name: _____ Contact Name: _____

Contact By: Phone _____ E-mail _____ Other _____
Phone Number E-mail Address Specify Method

HOSPITAL ADMISSIONS EXPECTED (DISASTER RELATED ONLY)

Total Current Hospital Admissions:		_____
Total Potential for Expected Hospital Admissions	(+)	_____
Total Hospital Admissions Expected	(A)	_____

TYPE O (BOTH + AND -) RBC AVAILABLE

Total Type O RBC at Hospital:		_____
Type O RBC Needed for Non-Disaster Related Need	(-)	_____
Total of Type O RBC Available	(B)	_____

CALCULATE THE TOTAL NUMBER OF UNITS NEEDED

Total Hospital Admissions Expected	Multiply (A) by 3	=	Total Type O RBC Needed	(-)	minus	Total Type O RBC Available	=	Total Type O RBC Needed from CBC/CTS
_____ (A)	X 3 units		_____	-		_____ (B)		_____

Available Storage Space: Freezer _____ # Units that could be stored Refrigerator _____ # Units that could be stored

Completed By: _____ Date: _____