

East Texas Gulf Coast Regional Trauma Advisory Council

Hospital Needs Assessment

FYE 2017 (09/01/17 – 08/31/18)

Hospital Name: _____

Date Completed: _____

1) Is your facility trauma designated? Y or N OR Is your facility in active pursuit of trauma designation? Y or N If yes, at what level? _____

2) Do you have an education program? Y or N Please supply us with the number of instructors for each education program:

ITLS _____

ABLS _____

PHBLS _____

ACLS _____

PALS _____

TNCC _____

ENPC _____

TCAR _____

ATLS _____

Car seat inspector _____

Other - Course Name? _____ # of Instructors _____

Other - Course Name? _____ # of Instructors _____

3) Is your facility interested in hosting education or injury prevention programs? Y or N

4) Describe in detail your injury prevention programs, use additional pages if necessary.

5) Describe in detail issues your facility has identified that need correcting to improve trauma care in your facility, use additional pages if necessary.

6) How can the RAC assist your facility to improve trauma care, use additional pages if necessary?

If you have needs please fill out the tables below.

Equipment Needs

Equipment	#1 Priority	#2 Priority	#3 Priority	Do you have plans to meet these needs	Matching Funds Available Y/N

Educational Needs

Course Needed	Training Equipment Needed	# Students Needing Initial Training	# Students Renewing	Do you have plans to meet these needs	Matching Funds Available Y/N

Public Injury Prevention

Program Needed	Equipment Needed	Supplies Needed	Target Audience	Follow-up	Matching Funds Available Y/N

Training / Clinical Coordinator's name and email address?

Injury Prevention Coordinator's name and email address?

Stroke Coordinator's name and email address?

Do you have a nursery? Y or N

If Yes, What is the name and email address of your Perinatal Coordinator?

Who completed this form?

Print

Sign

TSA "R" member signature: _____