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HOSPITAL TO POST-ACUTE CARE FACILITY TRANSFER COVID-19 ASSESSMENT

INSTRUCTIONS: Hospitals are encouraged to use this form to document your assessment of the COVID-19 status of all hospitalized prior to transfer to a post-acute care facility. CHECK THE BOX FOR EACH CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:

Patient Name _____

Transferring Facility _____

Accepting Facility _____

Has patient been laboratory tested for COVID-19?

☐ **YES,** Patient tested for COVID-19
Date of test(s) _____
What was the indication for testing? _____

☐ **NO**

☐ Results Pending
Check if any results are pending

↓

☐ **Await Results MAY NOT TRANSFER**

*To accept transfer, receiving facility must have sufficient staff and supplies/equipment to provide the necessary care.

☐ Negative Test
Check only if all results are negative

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☐ **Is another COVID-19 test planned/pending?**

☐ **YES**

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Await Results MAY NOT TRANSFER

☐ **NO**

Any new signs/ symptoms of respiratory illness (e.g. fever, cough, sore throat or shortness of breath) since last negative test?

☐ **NO**

Exposure/travel in the past 14 days: Has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, been exposed to a person who has been lab tested positive for COVID-19, or been exposed to another person suspected to have COVID-19?

☐ **NO**

↓

MAY TRANSFER*

☐ **YES** Last known date of exposure: _____

☐ **< 14 days**

↓

Complete 14-day quarantine before transferring

☐ **> 14 days**

↓

MAY TRANSFER*

☐ **YES**

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Require a repeat COVID-19 test

☐ Positive Test
Check if any one test resulted positive

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Does the patient meet all 3 criteria:
1. Resolution of fever without fever reducing medications, 2. improvement in respiratory symptoms AND 3. two negative COVID-19 test >24 hour apart

☐ **YES**

↓

MAY TRANSFER*

☐ **NO**

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May not transfer unless transfer is to facility equipped to maintain transmission-based precautions

Does patient have any signs/symptoms of respiratory illness (e.g. fever, cough, sore throat or shortness of breath)?

☐ **NO**

Exposure/travel in the past 14 days: Has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, been exposed to a person who has been lab tested positive for COVID-19, or been exposed to another person suspected to have COVID-19?

☐ **YES**

↓

Need COVID-19 test

☐ **YES**

☐ **NO**

→ **MAY TRANSFER***

Provide copy of completed form to EMS/transport agency.

__ Clinical assessment (signs and symptoms) discussed with treating MD/PA/NP

Name of person completing form (print name) Date/Time

Reported to (name of facility staff) Date/Time

Place patient identification label here

Form updated 4/9/20