

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

Negative Test
 Check only if all results are negative

Is another COVID-19 test planned/pending?

YES **NO**

Positive Test
 Check if any one test resulted positive

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 **NO**

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

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

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 **YES**

NO
 MAY TRANSFER*

YES Last known date of exposure: _____

< 14 days > 14 days

Complete 14-day quarantine before transferring **MAY TRANSFER***

Require a repeat COVID-19 test

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

NO **YES**

NO **YES**

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 **YES**

Need COVID-19 test **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