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 OF THE CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:

Patient Name: _____

Transferring Facility: _____ Accepting Facility: _____

Has patient been laboratory tested for COVID-19?

COVID-19 testing criteria for elderly/medically frail patients – Update 3/18/2020

- Patients age 65 and older or patients with serious underlying medical conditions *AND*
- Patient presents with new onset fever AND cough OR other respiratory signs including shortness of breath

☐ **YES, Patient tested for COVID-19**

Date of test _____

What was the indication for testing?

☐ **NO, Test NOT INDICATED per Centers for Disease Control (CDC) criteria. MAY TRANSFER**

☐ **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, exposed to a person who has been lab tested positive for COVID-19, is an immunocompromised person, or has been exposed to another person confirmed to have COVID-19.

Dates of travel _____ Date(s) of exposure _____

☐ **Respiratory** Signs/symptoms of a respiratory illness (cough, sneezing, fever>100, shortness of breath, sore throat).

☐ **Results Pending** ☐ **Negative test** ☐ **Positive test**

If the patient was tested due to travel/exposure criteria, are they still in the 14 day post travel/exposure period where isolation is required?

☐ **YES** ☐ **NO/Not Applicable**

SELF-QUARANTINE FOR 14 DAYS

MAY TRANSFER

Does patient meet criteria outlined in *CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19?*

☐ **YES** ☐ **NO**

If the patient was tested due to travel/ exposure criteria, are they still in the 14 day post travel/exposure period where isolation is required?

☐ **YES** ☐ **NO**

MAY NOT TRANSFER

MAY TRANSFER

MAY NOT TRANSFER UNLESS TRANSFER IS TO FACILITY EQUIPED TO MAINTAIN TRANSMISSION -BASED PRECAUTIONS

Clinical Assessment Completed by (print name) Date/Time

Reported to (name of facility staff) Date/Time

Provide copy of completed form to EMS/transport agency.

LeadingAge PA

PACAH Pennsylvania Coalition of Affiliated Healthcare & Living Communities

PALA

HAP The Hospital + Healthsystem Association of Pennsylvania

PHCA Pennsylvania Health Care Association

Form updated as of 3/23/20

Place patient identification label here