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

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

☐ **YES** → **Await Results MAY NOT TRANSFER**

☐ **NO** → Any new signs/symptoms of respiratory illness since last negative test? (See www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html for complete list)

☐ 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 symptoms AND 3. More than 20 days have passed since onset of symptoms

☐ **YES** → **MAY TRANSFER***

☐ **NO** → May not transfer unless facility is equipped to maintain transmission-based precaution (Facilities may decide to discontinue transmission-based precaution for COVID-19 earlier than 20 days in some specific cases based on the most recent CDC guidance www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

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** → **Require a repeat COVID-19 test**

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

- ☐ **<** 14 days → **Complete 14-day quarantine before transferring**
- ☐ **>** 14 days → **MAY TRANSFER***

Does patient have any signs/symptoms of respiratory illness? (See www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html for complete list)

☐ **NO**

☐ **YES** → **Need COVID-19 test**

Exposure/travel in the past 14 days: Has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruiseship, 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**

☐ **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 8/11/20