Hospital to Post-Acute Care Facility Transfer – COVID-19 Assessment

INSTRUCTIONS: All hospitalized patients should be assessed for COVID-19 prior to transfer to a post-acute care facility. This tool should be used to document an individual’s medical status related to COVID-19 and to facilitate communication between the hospital and the receiving facility during patient transfers. This document must be signed-off by the physician, APRN, or PA who completes the clinical assessment. 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?

☐ YES, Patient tested for COVID-19
   Date of test
   What was the indication for testing?

☐ NO, Test was NOT INDICATED per CDC testing criteria. May transfer.

☐ Travel/Exposure In the past 14 days, has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, or exposed to a person who has been lab tested positive for 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).

☐ Negative 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

☐ MAY NOT TRANSFER ☐ MAY TRANSFER

☐ Positive test

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

Clinical Assessment Completed by [signature]

Date/Time __________________________

Reported to [name of facility staff]

Date/Time __________________________