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

INSTRUCTIONS: In planning for transfer of a patient to a post-acute care facility, hospitals are REQUIRED to test patients for COVID-19 within approximately 48 hours, prior to transfer to a post-acute care facility, including nursing homes, assisted living, intermediate care, developmentally disabled and group home facilities. This assessment format facilitates documentation of compliance of the transferring hospital with Agency for Health Care Administration (AHCA) Emergency Rule 59AER20-1, that became effective May 5, 2020.

Patient Name: _______________________________________________________________________________________

Transferring Hospital: _________________________________ Accepting Facility:____________________________________

Check the appropriate box to indicate this patient’s current COVID-19 test status:

This patient has tested NEGATIVE for COVID-19 during this admission.

☐ The required negative COVID-19 test result is submitted along with this transfer form. [Only one negative test is required for patients who have never previously tested positive for COVID-19.]

This patient previously tested POSITIVE for COVID-19.

☐ The patient is now COVID-19 negative as confirmed by the required two (2) consecutive NEGATIVE COVID-19 test results separated by 24 hours. Additional testing within 48 hours of transfer is not required. [Documentation of these tests must be submitted along with this transfer form.]

☐ The patient is COVID-19 POSITIVE and continues to require isolation precautions for COVID-19. The accepting post-acute care facility can provide the dedicated wing, unit, or building and dedicated staff that are required by AHCA to accept COVID-19 patients.


This patient’s COVID-19 test result is PENDING.

☐ The patient has no symptoms of COVID-19, there is no reason to suspect the patient may be positive for COVID-19 and the accepting facility can provide a single-person room or a separate observation area so the resident can be appropriately isolated and monitored for evidence of COVID-19 status until such time the pending test demonstrates they are COVID-19 negative and they remain afebrile and without symptoms.

Date test submitted: ________________________________ Testing lab: _______________________________________

Clinical Assessment Completed by (signature) Date/Time

Reported to (name of facility staff) Date/Time

Form updated as of 6/10/20