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:

Primary reason the patient was admitted to the hospital? _____

Patient Name: _____

Transferring Facility: _____ Accepting Facility: _____

Has patient been laboratory tested for COVID-19?

☐ YES, Test Performed for COVID-19
Date of test _____
Expected Date of Results (if still pending) _____

☐ NO, test not performed because patient did not meet the 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, fever>99.6, 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 | MAY NOT TRANSFER

Clinical Assessment Completed by (signature)

Date/Time

Reported to (name of facility staff)

Date/Time

Notes:

TEXAS Health and Human Services

Form updated as of 3/20/20