

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

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**

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

MAY NOT TRANSFER

MAY TRANSFER

Clinical Assessment Completed by (signature) _____

Date/Time _____

Reported to (name of facility staff) _____

Date/Time _____

