# 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 OF THE CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:**

Patient Name: _____

Transferring Facility: _____ Accepting Facility: _____

## Has patient been laboratory tested for COVID-19?

COVID-19 testing criteria for elderly/medically frail patients – Update 3/18/2020

- Patients age 65 and older or patients with serious underlying medical conditions *AND*
- Patient presents with new onset fever 100.4 or greater AND cough OR other respiratory signs including shortness of breath

☐ **YES, Patient tested for COVID-19**

Date of test_____

What was the indication for testing?

☐ **NO, Test NOT INDICATED per CDC/AHCA/FDOH 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, exposed to a person who has been lab tested positive for COVID-19, or is an immunocompromised person.

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**

**MAY NOT TRANSFER**

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

VHCAVCAL LeadingAge Virginia

*Form updated as of 3/27/20*