HOSPITAL TO FACILITY TRANSFER — COVID-19

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. **A copy of the form should be provided to the EMS provider.**

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 — Updated 3/23/2020

- 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 criteria **OR, in patient with COVID diagnosis,** no fever for the last 72 hours without fever reducing medications and improvement in respiratory symptoms **AND** at least 7 days have passed since symptoms first appeared.

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.

☐ **Respiratory** Signs/symptoms of a respiratory illness (cough, sneezing, fever>100.4, shortness of breath, sore throat).

☐ **Negative test**

- ☐ Patient greater than 14 days since travel/exposure → **MAY TRANSFER**
- ☐ Patient less than 14 days since travel/exposure → **TRANSFER TO FACILITY WITH APPROPRIATE STAFF, PPE AND SPACE**

☐ **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** → **MAY TRANSFER**
- ☐ **NO** → **TRANSFER TO FACILITY WITH APPROPRIATE STAFF, PPE AND SPACE**

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Clinical Assessment Completed by (signature)

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Date/Time

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Reported to (name of facility staff)

____

Date/Time

MHA MISSOURI HOSPITAL ASSOCIATION

MHCA Missouri Health Care Association

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Form updated as of 3/31/2020