Inter-Facility Transfer – COVID-19 Assessment

INSTRUCTIONS: All pre-transfer patients/residents should be assessed for COVID-19 prior to transfer to a receiving facility. This tool should be used to document an individual's medical status related to COVID-19 and to facilitate communication between the transferring and the receiving facility during patient/resident 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/RESIDENT'S STATUS:

Patient/Resident Name & DOB: _____ **Transferring Facility:** _____

Length of stay_____ **Accepting Facility:** _____ **Vaccination Date(s) if applicable:**_____

Has patient/resident been laboratory tested for COVID-19?

☐ **YES, Patient/Resident 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/resident been to any restricted travel areas, traveled internationally, attended large gatherings, or been exposed to a person who has lab tested positive for COVID-19?

Travel location & Date: _____ Date(s) of exposure_____

☑ **Symptoms**
Fever/Cough/SOA/Chills/Sore Throat/ Headache/Nausea or Diarrhea/Impaired Smell or Taste/Fatigue/ Other_____

☐ **Negative test**

If the patient/resident 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**

- YES → **MAY NOT TRANSFER**
- NO/Not Applicable → **MAY TRANSFER**

☐ **Positive test**

Does patient/resident meet criteria outlined in *CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19?*

☐ **YES** ☐ **NO**

- NO → **MAY NOT TRANSFER**
- YES → If the patient/resident was tested due to travel/exposure criteria, are they still in the 14 day post travel/exposure period where isolation is required?

  ☐ **YES** ☐ **NO**

  - YES → **MAY NOT TRANSFER**
  - NO → **MAY TRANSFER**

_____
Clinical Assessment Completed by (signature)

_____
Date/Time

_____
Reported to (name of facility staff)

_____
Date/Time