This tool is for sending and receiving facilities to document a patient’s medical status related to COVID-19. All hospitalized patients should be assessed for COVID-19 prior to transfer to a post-acute facility.

Resident/Patient Name: ____________________________________________

Transferring Facility: _____________________________________________

Accepting Facility: ______________________________________________

Date of Transfer: ________________________________________________

Has the 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
  and/or DC Health 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

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

Clinical Assessment Completed by (signature) _______________________

Date/Time __________________________

Reported to [name of facility staff] ____________________________

Date/Time __________________________

If you reached this point in your screening contact the appropriate representative to discuss patient history and facility status.