Nursing Facility and Assisted Living Transfer to Hospital COVID-19 Communication Tool

This transfer document is supplemental to the traditionally required transfer documents and information. Use this tool to document an individual’s medical status related to coronavirus disease 2019 (COVID-19) to help facilitate communication between skilled nursing facilities and hospitals during patient transfers and admissions.

1. Has the patient tested positive for COVID-19?
   - Yes □  No □

2. Date of initial positive test: ________________________

3. If Yes, has the patient had 2 subsequent negative test results?
   - Yes □  No □  N/A □

4. Dates of subsequent negative tests: __________________
   If patient was positive and has subsequent negative testing STOP and call the receiving facility to have further discussion regarding current clinical status of the patient.

5. Has the patient exhibited signs and symptoms of COVID-19 during admission to the facility (Cough, Sneezing, Fever > 100, SOB, Sore Throat)?
   - Yes □  No □

6. Has the patient had a positive chest x-ray since admission?
   - Yes □  No □  N/A □

7. If answer to 6 is Yes, results: ________________________

8. Has the patient been in contact with anyone who has tested positive for COVID-19?
   - Yes □  No □

9. Date of Exposure: ____________________________

10. Has the patient been to any of the restricted travel areas (South Korea, Iran, China, Italy), traveled internationally or traveled on a cruise ship in the last 14 days?
    - Yes □  No □

11. Dates and countries of travel: __________________

12. Has anyone in your facility tested positive for COVID-19 or has been presumed positive?
    - Yes □  No □

13. If Yes to Question 12: Has the Department of Health Been Notified?
    - Yes □  No □  N/A □

If the answer is “Yes” to question 12, STOP and have a conversation with receiving center regarding facility status.

Signature of Screener: ____________________________
Title: __________________________________________
Date: __________________ Time: __________________

Report Called in to: ____________________________
Date: __________________ Time: __________________

Resident/Patient Name: _______________________________________________________________________
Transferring Facility: ______________________________________________________________________
Accepting Facility: ________________________________________________________________________
Date of Transfer: _________________________________________________________________________

Iowa Health Care Association
Iowa Center for Assisted Living
Iowa Center for Home Care

Iowa Hospital Association
LeadingAge Iowa