

COVID-19 Hospital Transfer Coversheet

Notify EMS of COVID-19 Status

Resident Identifiers	Name: _____	Gender: M F
	DOB: _____	Language: _____
Family Contact/POA	Name: _____	Phone #: _____
	Is this person the POA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing Facility Info	Nursing Facility Name: _____	Callback #: _____
Hospital Info	Hospital Name: _____	Nurse report given to: _____
Medical Provider Contact	Name: _____	Callback #: _____
Advance Directives	<input type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> POST If POST: <input type="checkbox"/> Comfort Measures <input type="checkbox"/> Limited Additional Interventions <input type="checkbox"/> Full Interventions	

Reason for transfer:

Chronic medical issues related to transfer:

Date signs and symptoms started: _____

New symptoms include:

- Elevated temp. (>99.0) Cough SOB Abdominal pain Diarrhea
 Fatigue Sore throat Muscle aches N/V Chest pain

Has the resident been tested for COVID-19: Yes, date: _____ No: _____

If YES: Positive Negative Pending Droplet Isolation Lab name: _____

Have any nursing facility residents or staff tested positive for COVID-19? Yes No

Last V/S-Time _____ **B/P** _____ **HR** _____ **RR** _____ **Temp** _____ **O₂ Reading** _____ **O₂ Required** _____

Has fever reducing medication been given in the last 4 hrs? Yes No

Describe functional baseline: _____

Describe cognitive function baseline: _____

Does this resident have a dx of dementia: Yes No