# Transfer and Admissions Checklist

Please use this form to assess requests for transfer/repatriation or new admission to LTCH/RH/Congregate Living/Complex Continuing Care Facility when the hospital/transferring facility and/or receiving facility is in declared outbreak.

**To avoid unnecessary delays, please complete form in full before notifying Public Health Sudbury & Districts of discharge readiness.** Information to be provided regardless of type of outbreak (enteric, respiratory, COVID-19).

For COVID-19 outbreaks, refer to [Appendix E](https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/LTCH_RH_guidance_PHU.pdf) for direction. If guidance identifies that Public Health Sudbury & Districts (PHSD) consultation is required, please fax this form to PHSD as per information in Section 4.

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| Transferring Facility name: Click or tap here to enter text. |
| Receiving Facility name: Click or tap here to enter text. |
| Facility in outbreak: Transferring facility  Receiving Facility  Both facilities  Outbreak Number(s): Click or tap here to enter text. |
| Type of outbreak (if applicable): Enteric  Respiratory  COVID-19 |

**Section 1: Information to be completed by Transferring Facility**

**Section 1.1: Transferring Facility Information**

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| Facility name: Click or tap here to enter text. | |
| Contact name: Click or tap here to enter text. | |
| Phone number: Click or tap here to enter text. | Fax number: Click or tap here to enter text. |
| Date of transfer request: Click or tap to enter a date. | Time of transfer request: Click or tap here to enter text. |

**Section 1.2: Resident/Disease Information**

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| Patient/Resident Name (First, Last): Click or tap here to enter text. |
| Resident date of birth: Click or tap to enter a date. |
| Type of transfer: New admission  Transfer/Repatriation |
| Is **current** resident/patient **room** part of an outbreak? Yes  No |
| Is the resident a COVID-19 case? Yes  No |
| Date last COVID-19 test completed: Click or tap to enter a date. PCR  Molecular  RAT |
| Is the resident a HRCC of a COVID-19 case? Yes  No |

**Section 1.3: Patient Symptom/Disease Record**

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| Has the patient experienced any enteric symptoms (diarrhea/vomiting)? Yes  No |
| Last episode date: Click or tap to enter a date. |
| Stool sample collection date (if applicable): Click or tap to enter a date. |
| Result (if applicable): Click or tap here to enter text. |
| Has the patient experienced any respiratory/COVID-19 symptoms? Yes  No |
| Onset Date: Click or tap to enter a date. |
| Multiplex respiratory virus PCR (MRVP) collection date: Click or tap to enter a date. |
| Result(s): Click or tap here to enter text. |
| Has the patient received OR is patient receiving Tamiflu? Yes  No  N/A |
| Treatment (75 mg twice daily)  Prophylaxis (75 mg once daily) |
| Has the patient received OR is patient receiving Paxlovid? Yes  No  N/A |

**Section 1.4: FOR HOSPITAL USE ONLY**

|  |
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| Date of admission to hospital/facility: Click or tap to enter a date. N/A |
| Admission diagnosis: Click or tap here to enter text. N/A |
| Discharge diagnosis: Click or tap here to enter text. N/A |
| Does discharging physician agree to transfer or new admission to a facility in outbreak?  Yes  No  N/A  (for facilities not in outbreak) |
| Has the resident or SDM/POA been advised of and consent to admission or transfer to a home in outbreak? They have been provided information on the measures that are in place to reduce the risk of exposure in the facility.  Yes  No  N/A  (for facilities not in outbreak) |
| Does the receiving facility agree to the transfer of the resident? Yes  No |

**Section 2: Information to be completed by resident’s Facility of Residence**

* To be completed by LTCH/RH/Congregate Living/Complex Continuing Care (CCC) Facility, at which client is currently a resident/patient prior to transfer to hospital.
* Ensure this completed form is included in the resident/patient transfer package (e.g., with transfer form/medication profile/DNR).

**OR**

* To be completed by Home and Community Care if the resident is a new admission.

**Note: All fields are mandatory for a final decision to be made by Public Health Sudbury & Districts.**

**Section 2.1: Patient Information and Immunization Record**

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| Is the resident/patient able to adhere to all required public health measures, as required (e.g. mask use, isolation)? Yes  No |
| Is the resident a previous positive case in the last 90 days? Yes  No |
| Date of previous positive test: Click or tap to enter a date. |
| Is the resident/patient immunized against influenza? Yes  No  Date: Click or tap to enter a date. |
| Is the resident immunized against COVID-19? Yes  No |
| Dose 1  Date: Click or tap to enter a date. Dose 2  Date: Click or tap to enter a date. |
| Dose 3  Date: Click or tap to enter a date. Dose 4  Date: Click or tap to enter a date.  \*Review guidance for definition of fully vaccinated when determining if resident is up to date |

**Section 3: Information to be completed by receiving facility**

* To be completed by the hospital if admitting a patient/resident to a facility. **OR**
* To be completed by the LTCH/RH/Congregate Living/Complex Continuing Care (CCC) Facility if admitting/receiving a patient/resident.Ensure all information is completed prior to requesting transfer approval from Public Health Sudbury & Districts.
* Fax to Public Health Sudbury & Districts as per information in Section 4.

**Section 3.1: Receiving Facility Information**

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| Name of receiving facility: Click or tap here to enter text. | |
| Contact name: Click or tap here to enter text. | |
| Phone number: Click or tap here to enter text. | Fax number: Click or tap here to enter text. |
| Resident/patient will be transferring to:  Room number: Click to enter text. Floor/Unit: Click to enter text. Private room  Shared room  Shared bathroom  Private bathroom | |
| Is resident/patient room part of an outbreak: Yes  No | |
| Outbreak number: Click or tap here to enter text. | |
| If returning to shared room. Is roommate any of the following:  Active COVID-19 case  Previous positive (last 59 days)  High risk close contact  None  Other (specify): Click or tap here to enter text. | |
| Requested admission date: Click or tap to enter a date. | |

### Section 4: Contact Information

### Fax or email the completed checklist to:

* Public Health Sudbury & Districts confidential fax: 705.677.9618 or email [HPT\_FAX\_CONFIDENTIAL@phsd.ca](mailto:HPT_FAX_CONFIDENTIAL@phsd.ca?subject=PHSD%20Transfer%20Return%20Checklist) **AND**
* HSN Patient Flow Office fax: 705.675.4771 (if applicable)
* If faxing or sending by email after hours (16:30 to 8:30 weekdays, or anytime on weekends and holidays), call 705.688.4366 to advise of incoming fax or email

### For status inquiries regarding transfer’s call:

* Enteric outbreaks: 705.522.9200, ext. 464
* Respiratory outbreaks: 705.522.9200 ext. 267 or email [LTCH@phsd.ca](mailto:LTCH@phsd.ca?subject=PHSD%20Transfer%20Return%20Checklist)
* After hours: 705.688.4366 (16:30 to 8:30 weekdays, or anytime on weekends and holidays)

**Note:** HSN Patient Flow Office can be reached at705.522.2200, ext. 1044 (if applicable).

**Public Health Sudbury & Districts will determine if the resident meets criteria for transfer or admission to facility based on the information provided and will notify the hospital or transferring facility.**