# Transfer and Admission Assessment Form

Please use this form to assess transfers or new admissions to LTCH/RH/Congregate Living/Complex Continuing Care Facility when the hospital, transferring facility, or receiving facility is in declared outbreak.

The hospital or transferring facility is to complete and **submit this form to the receiving facility for review and approval within 48 hours of requested transfer or admission date**. Transfer or admission should not proceed until the receiving facility has approved.

The receiving facility will utilize the *Transfer and Admission Flowchart* for scenarios outlined in section 3.5 of [*Recommendations for Outbreak Prevention and control in Institutions and Congregate Living Settings*](https://www.ontario.ca/files/2024-11/moh-recommendations-for-outbreak-prevention-and-control-in-institutions-and-cls-en-2024-11-01.pdf)(PDF).

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| **Section 1: To be completed by the transferring facility** |
| Section 1.1: Tansferring facility information |
| Transferring facility name and unit/floor: Click or tap here to enter text. |
| Facility contact name: Click or tap here to enter text. |
| Phone number: Click or tap here to enter text. Confidential fax number: Click or tap here to enter text. |
| Section 1.2: Transfer information |
| Is the transferring unit or floor where the resident or patient’s room is located in outbreak? Yes  No  If yes, please provide the outbreak information below:  Outbreak Number: Click or tap here to enter text.  Type of outbreak: Enteric ☐ COVID-19 ☐ Influenza ☐ Respiratory (other) ☐ |
| Date of proposed transfer: Click or tap to enter a date. Time of proposed transfer: Click or tap here to enter text. |
| Type of transfer: New admission  Transfer |
| Section 1.3: Resident or patient information and immunization record | |
| Resident or patient Name (first, last): Click or tap here to enter text. | |
| Resident or patient date of birth: Click or tap to enter a date. | |
| Date the resident or patient was admitted to facility or hospital: Click or tap to enter a date. | |
| Is the resident or patient able to adhere to all required infection prevention and control measures (IPAC), as needed (for example, mask use, isolation, or hand hygiene)? Yes  No | |
| Is the resident or patient severely immunocompromised? Yes  No | |
| Is the resident or patient immunized with the most recent season’s influenza vaccine?  Yes  No  Date: Click or tap to enter a date. | |
| Is the resident or patient immunized against COVID-19? Yes  No  Most recent dose date: Click or tap to enter a date.  \*The most up to date COVID-19 vaccine should be used for the annual dose for both previously vaccinated and unvaccinated individuals. For current COVID-19 vaccination recommendations, see [COVID-19 Vaccine Program/ontario.ca](https://www.ontario.ca/page/covid-19-vaccine-program) | |
| Is the resident or patient immunized against RSV? Yes  No  Date: Click or tap to enter a date. | |
| Is the resident or patient a close contact of a case (respiratory, influenza, COVID-19 or enteric)? Yes  No | |

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| Section 1.4a: Resident or patient symptom or disease record |
| Is the resident or patient currently symptomatic or an active case (respiratory, influenza, COVID-19 or enteric)?  Yes  No  **If yes**, complete symptom information below. **If no**, please skip to section 1.4b. |
| Has the resident or patient experienced any enteric symptoms (such as diarrhea or 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 resident or patient experienced any respiratory or 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. |
| Section 1.4b: Treatment or prophylaxis |
| Has the resident or patient received OR is receiving Tamiflu? Yes  No  N/A |
| Treatment (75 mg twice daily)  Prophylaxis (75 mg once daily) |
| Has the resident or patient received OR is receiving Paxlovid? Yes  No  N/A |
| Section 1.5: Consent |
| If the receiving facility is in outbreak, has the resident or SDM/POA been advised of the outbreak, informed of the IPAC measures in place to reduce the risk of exposure in the facility, and consented to admission or transfer?  Yes  No  N/A  (for facilities not in outbreak) |
| If hospital is the transferring facility, does discharging physician agree to transfer or admission to a facility in outbreak?  Yes  No  N/A  (for facilities not in outbreak, or if not transferring from hospital) |

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| **Section 2: To be completed by receiving facility** |
| Section 2.1: Receiving facility information |
| 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 or patient will be transferring to:  Room number: Click to enter text. Floor/Unit: Click to enter text. Private room with private bathroom  Private room with shared bathroom  Shared room |
| Is resident or patient requested room part of an outbreak unit: Yes  No |
| Outbreak number: Click or tap here to enter text. |
| Does the area/unit have clients/patients/residents who are unable to isolate and/or follow IPAC measures? Yes  No |
| If being admitted or transferring to shared room, is roommate any of the following:  Active COVID-19, respiratory or enteric case  Symptomatic  Close contact  None  Other (specify): Click or tap here to enter text. |

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| **Section 3: Transfer or admission approval status** |
| Transfer or admission is approved: Yes No Re-submission is required |
| If not approved or re-submission is required, please indicate reason:  Incomplete form  Public Health *Transfer and Admisision Flowchart* criteria was not met (specify below) |
| Please describe why approval criteria not met:  Outbreak unstable  Private room required and not available  Person/POA consent not received  Individual or other residents/patients unable to follow IPAC\* measures and facility unable to support compliance  Physician consent not received  Person is severely immunompromised  Other  \*IPAC= infection prevention and control |

**Fax or email the completed checklist to:**

* Receiving facility. Please contact receiving facility for confidential email or fax number and send upon completion of all sections, for review by receiving facility.
* Communication with Health Sciences North (HSN) regarding transfers must be done with HSN Patient Flow, via office fax: 705.675.4771 or 705.522.2200, ext. 1044.
* For all other transferring facilities, receiving facilities are to return the transfer to the identified contact or department.

Receiving facility is to utilize the *Transfer and Admission Flowchart* where Public Health guidance is required. For scenarios not captured in the flowchart, or if there are additional concerns, receiving facility is to contact Public Health. Receiving facility will notify the hospital or transferring facility of approval status.

**If additional consultation is required please contact Public Health:**

**During business hours (Monday-Friday 8:30-4:30)**

Fax: 705.677.9618 or email [HPT\_FAX\_CONFIDENTIAL@phsd.ca](mailto:HPT_FAX_CONFIDENTIAL@phsd.ca?subject=PHSD%20Transfer%20Return%20Checklist)

Email: [LTCH@phsd.ca](mailto:LTCH@phsd.ca)

**For inquiries call:**

Enteric outbreaks: Public Health Inspector at 705.522.9200, ext. 464

Respiratory outbreaks: Public Health nurse at 705.522.9200, ext. 267 or email [LTCH@phsd.ca](mailto:LTCH@phsd.ca)

**After hours (after 4:30, weekends, and holidays):**

Fax the completed form AND call 705.688.4366 to advise of the incoming fax. Inquiries may also be directed to 705.688.4366.