Transfer and Admission Assessment Form

Public Health
Santé publique
SUDBURY & DISTRICTS

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* (PDF).

Section 1: To be completed by the transferring facility

Section 1.1: Tansferring facility information

Transferring facility name and unit/floor:

Facility contact name:

Phone number: Confidential fax number:

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:

Type of outbreak: Enteric ☐ COVID-19 ☐ Influenza ☐ Respiratory (other) ☐

Date of proposed transfer: Time of proposed transfer:

Type of transfer: New admission ☐ Transfer ☐

Section 1.3: Resident or patient information and immunization record

Resident or patient Name (first, last):

Resident or patient date of birth:

Date the resident or patient was admitted to facility or hospital:

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:

Is the resident or patient immunized against COVID-19? Yes ☐ No ☐
Most recent dose 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

Is the resident or patient immunized against RSV? Yes ☐ No ☐ Date:

Is the resident or patient a close contact of a case (respiratory, influenza, COVID-19 or enteric)? Yes ☐ No ☐

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:
Stool sample collection date (if applicable):
Result (if applicable):
Has the resident or patient experienced any respiratory or COVID-19 symptoms? Yes ☐ No ☐
Onset date:
Multiplex respiratory virus PCR (MRVP) collection date:
Result(s):
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)

Section 2: To be completed by receiving facility
Section 2.1: Receiving facility information
Name of receiving facility:
Contact name:
Phone number: Fax number:
Resident or patient will be transferring to: Room number: Floor/Unit: 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:
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):

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

Email: 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

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.