PROBARI
Proven systems to transform nursing home care.

COVID-19 Hospital Transfer Coversheet

Notify EMS of COVID-19 Status

Resident Identifiers	Name: DOB:	Gender: M F Language:
Family Contact/POA	Name: Is this person the POA? ☐ Yes ☐ No	Phone #:
Nursing Facility Info	Nursing Facility Name:	Callback #:
Hospital Info	Hospital Name:	Nurse report given to:
Medical Provider Contact	Name:	Callback #:
Advance Directives	☐ Full Code ☐ DNR ☐ POST If POST: ☐ Comfort Measures ☐ Limited Additional Interventions ☐ 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 _____ O_2 Reading _____ O_2 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