|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** / / | **Nurse Name:** | | **Nurse Initial:** |
|  |  | |  |
| **Pt. First Name:** | | **Pt. Last Name:** | |
| **Pt. DOB:**  / / | | **Pt. Phone #:** | |
| **Pt. Email:** | | | |
| **Address or where admitted from:** | | | |
| **Medical Home (Primary Care):** | | | |
| **Mental Health provider (Psychiatrist, psychologist, counselor; list all):** | | | |

**BASIC INFORMATION:**

|  |  |
| --- | --- |
| **Allergies:**  **N/A** | **Physical Accessibility Issues (wheelchair, hearing/visual impairment, etc.):**  **N/A** |
| **Cultural Considerations, specify:**  **N/A** | **Language:**  **N/A** |

**COVID-19 STATUS:**

Suspected case based on symptoms

Suspected case awaiting laboratory confirmation

Laboratory-confirmed case

Known exposure to confirmed case (Referral from PHD contact tracing)

**CURRENT SYMPTOMS, INTENSITY, DURATION, ONSET, FREQUENCY:**

**FEVER**

New  Worsening  Unchanged  Date of onset or worsening

None

**COUGH**

New  Worsening  Unchanged  Date of onset or worsening

None

**DIFFICULTY BREATHING**

New  Worsening  Unchanged  Date of onset or worsening

None

**DIARRHEA**

New  Worsening  Unchanged  Date of onset or worsening

None

**Other Symptoms:­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VITALS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **P:** | **RR:** | **T:** | **SpO2:** |

**MAJOR MEDICAL PROBLEM(S) -** (Indicate problems with check: Y or N )

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Problem** | **Yes** | **No** | **Problem** | **Yes** | **No** | **Problem** | **Yes** | **No** | **Problem** |
|  |  | Diabetes |  |  | Cardiovascular  disease |  |  | Liver disease |  |  | Hypertension |
|  |  | Asthma/lung disease |  |  | Thyroid disease |  |  | Renal disease |  |  | Renal Dialysis |
|  |  | Seizures/  Neurologic |  |  | Obesity  (est. BMI>40) |  |  | GI disease |  |  | Cancer |
|  |  | Immune disorder |  |  | Steroid use (eg  Prednisone) |  |  | Pregnancy |  |  | Blood dis or thinners |

**OTHER MEDICAL ISSUES/COMMENTS ETC.**

**MEDICATIONS:**

|  |  |
| --- | --- |
| **List current medications:**  **N/A** | **Pharmacy**  **(Transfer Rx to Midtown Pharmacy if Poss)**  **N/A** |
| **Are Refills Needed?**  Yes  No  **(See Table on Page 9)** | **OTC Medication Needs:**  **N/A** |

**NOTE:** **Do NOT** provide ibuprofen

**IHSS/CAREGIVER:**

|  |  |
| --- | --- |
| **Does the individual have an outside IHSS/Caregiver?**  Yes  No | |
| **Name:** | **Contact Info:** |
| **Have they been working closely with them in the past week?**  Yes  No | |
| **Frequency of Need/Schedule for Visits:** | |
|  | |
| **Does the individual need an outside IHSS/Caregiver?**  Yes  No | |

**NOTE:** If they do not currently have a provider but needs support with IADLs, refer to FAST

**SUICIDAL THOUGHTS/ATTEMPTS:** *“Columbia Suicide Severity Rating Scale Screener (LACDMH Version)”*

Wish to be Dead: *Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.*

1. **Within the past 30 days, have you wished you were dead or wished you could go to sleep & not wake up?**

Yes  No

Suicidal Thoughts: *General non-specific thoughts of wanting to end one’s life/commit suicide, “I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.*

1. **Within the past 30 days, have you actually had any thoughts of killing yourself?**

Yes  No

***If YES to 2****, ask all questions 3, 4, 5, and 6*  ***If NO to 2****, go directly to question 6*

Suicidal Thoughts with Method (without Specific Plan or Intent to Act): *Person endorses thoughts of suicide and has thoughts of at least one method during the assessment period.*

1. **Have you been thinking about how you might kill yourself?**

Yes  No

Suicidal Intent (without Specific Plan): *Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts.*

1. **Have you had these thoughts and had some intention of acting on them?**

Yes  No

Suicide Intent with Specific Plan: *Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.*

1. **Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?**

Yes  No

Suicidal Behavior:

1. **Have you done anything, started to do anything, or prepared to do anything to end your life?**

Yes  No

|  |
| --- |
| **If yes, how long ago did you do any of these?** |
| **Additional comments regarding SA/SI:** |
| **Self-Harm (without suicidal intent):**  Yes  No  Unable to assess |
| **If yes, describe:** |
| **SAFETY PLAN** (if indicated): |

**SUD SCREEN:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DRUG SCREENING QUESTIONS** (“Yes” to any of the questions below indicates a positive screening) | | | | |
|  | **Ever Used?** | | **Recently Used (6mo)** | |
|  | **Yes** | **No** | **Yes** | **No** |
| **1. Have you used nicotine products? (Cigarettes, cigars, electronic cigarettes, smokeless tobacco)** |  |  |  |  |
| **2. Have you used opioids? (Heroin, opium, non-prescribed pain medications)** |  |  |  |  |
| **3. Have you used stimulants, such as cocaine or methamphetamine?** |  |  |  |  |
| **4. Have you used other substances of abuse?** |  |  |  |  |
| **Are you interested in changing your substance use patterns?**  Yes  No  N/A  **Are you currently in a residential or outpatient treatment program for substance use? Name and contact of program?** Yes  No  (If YES, check the box on the alcohol log, “Is this person guest referred or currently receiving care…”)  **Name and contact for program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(List of programs is posted in intake area.)**  **Are you interested in Suboxone treatment?** Yes  No  **(If YES, see PAGE 8)** | | | | |

**Alcohol Use Screening:**

|  |  |
| --- | --- |
| 1. Do you currently drink alcohol? | **No 🡪 Stop, Enter guest in “Low Risk” log**  **Yes 🡪 Go to 2** |
| 1. How much and how often? | **Less than 4 drinks every day?**  **More than 4 drinks every day** |
| 1. Have you had seizures or “DTs” when you stopped? | **Yes**  **No** |
| 1. Have you ever had withdrawal symptoms when you stopped? What kind? | **Yes**  **No** |

**“Less than 4 drinks every day” AND “No” to 3 & 4 🡪 Enter guest in “Low Risk (Blue)” log**

**“More than 4 drinks every day” OR any Yes 🡪 Enter guest in “High Risk (Yellow)” log**

**We know it will be hard to stay in your room. How can we plan together for what might make you want to leave your room?**

***(Prompt the guest with specific examples:*** *What can we do to make you feel comfortable while you’re here? Is there someone we can call to let them know you are here? What might make you feel you had to leave: Need for alcohol?  Need to see your partner?  Need for other substances? etc.)*

|  |
| --- |
| **PLAN (You may want to specifically address claustrophobia/confinement/secondary trauma here):** |

**NURSING “TO DO” LIST:**

**REFERRALS PROVIDED:**

**NURSING PLAN:**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*For guests interested Suboxone treatment\*\*\*\*\*\*

Monday-Friday:

-          8am -4:30pm: AHS-BRIDGE Program- Substance Use Navigator 510-545-2765

-          Same-day appointment usually possible

-          Inform the substance use navigator that this is a referral from a quarantine hotel site

After hours/Weekends

-          Contact a telemedicine provider on-call. If not X-Waivered (most are) call

Dr. Alter 510-520-1875

-          Weekend: will need to send prescription to a local pharmacy for abode staff to pick up.

-          If abode staff is picking up prescription for client, bring the following: staff badge, ID, and name & DOB of the guest.

|  |  |
| --- | --- |
| **Table 1: Scenario Based Protocol For Medication Refill** | |
| **Guest Scenario** | **Protocol** |
| Arrives with insufficient supply (<15 days) of medical or psychiatric medication | * Intake clinician should assess for available refills (may need to contact pharmacy). * If refills are available, then these refills may need to be transferred to Midtown Pharmacy (510-864-4199) for delivery to hotel site. * Call Midtown Pharmacy and request for Midtown staff to contact the client’s pharmacy and “transfer” the needed prescriptions and then deliver to the hotel site. See “notes for all prescribers and referring providers” for additional details to provide Midtown Pharmacy staff. * If refills are not available, then attempt to contact the client’s original prescriber; if contacting this prescriber is not possible or available then contact the appropriate telemedicine provider |
| Arrives with insufficient amount (<15 days) of methadone for opioid use disorder | Monday-Friday   * Contact the client’s opioid treatment program to coordinate treatment and explain the client’s quarantine status. * See table 2 for a list of NTPs and contact information. |
| Arrives with insufficient amount (<15 days) of medication assisted treatment for opioid, alcohol, or tobacco use disorders **(excluding methadone)** | Monday-Friday:   * Nurse or client can call AHS Substance Use Navigator 510-545-2765 to schedule an appointment with an AHS provider (same-day appointment possible). * The client may also call from their personal phone or hotel room. * As back-up, you may contact the Screening Clinician on duty |
| Emerging substance withdrawal symptoms or who anticipate onset of withdrawal symptoms during quarantine  Example:  -clients run out of cigarettes  -abruptly stopping alcohol  -no access to illicit opioids | Monday-Friday:   * Nurse or client can call AHS Substance Use Navigator 510-545-2765 to schedule an appointment with an AHS provider (same-day appointment possible). * The client may also call from their personal phone or hotel room. * As back-up, you may contact the Screening Clinician on duty |
| Other emerging symptom(s) | -Nursing staff may offer OTC medication if appropriate  -Nursing staff facilitates connection to a telemedicine provider |