**OPERATION COMFORT MD SCREENING TOOL**

Approved referral providers will notify OPERATION COMFORT of individuals who test positive for COVID-19, are persons under investigation (PUI), or are a suspected case based on screening.

**\*\*\*\*All guests must be appropriate for home self-quarantine.\*\*\*\***

[ ]  Patient Name & DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Patient Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Preferred Language [ ]  English [ ]  Spanish [ ]  Mandarin [ ]  Cantonese [ ]  Other ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Referrer Contact & Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Address/location/room # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Clinician Name & Contact number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Expected time & date of discharge (if in hospital): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Reason for referral: [ ] Corona Virus (+) [ ] Direct Exposure to COVID-19

[ ]  Under Investigation [Test Pending] [ ]  Under Investigation [Not Tested]

[ ]  Is patient symptomatic:

|  |  |  |
| --- | --- | --- |
| [ ]  None | [ ]  Fever > 100.4F | [ ]  Subjective Fever |
| [ ]  Cough | [ ]  Sore throat | [ ]  Runny nose |
| [ ]  Shortness of breath | [ ]  Chills | [ ]  Headache |
| [ ]  Muscle Ache | [ ]  Nausea or Vomiting | [ ]  Abdominal pain |
| [ ]  Diarrhea | [ ]  Other |

**☐** Symptom onset date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Medical Problems:

[ ]  **Congestive Heart Failure (CHF)**

[ ]  **Diabetes Mellitus (DM)**

[ ]  **Immune compromise \_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  **Mental Health Diagnosis**

[ ] **Extreme Obesity (BMI>40)**

[ ] **Opioid Use Disorder**

[ ] **Alcohol Use Disorder**

[ ] **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

[ ]  **Other chronic condition(s):**

[ ] Ambulatory Status:

[ ] Unassisted

[ ] With assistance

[ ]  cane

[ ]  crutches

[ ]  walker

[ ]  wheelchair

[ ] Able to attend to ADLs? **Yes** [ ]  **No** [ ]

[ ]  Appropriate for independent self-quarantine?

 (General clinical impression of guest's

ability to tolerate confinement)

 [ ]  Coronavirus Tested **Yes** [ ]  **No** [ ]

If yes, date of test: \_\_\_\_\_\_ Location\_\_\_\_\_

Result: [ ]  Positive

[ ]  Negative

[ ]  Pending

[ ]  Confirm discharge or send prescription discharged with 30-day supply of medications (if no meds available, send to the designated local community pharmacy)

Script:  "For guests coming from Hospital or Clinic: Please assure that the guest will arrive with EITHER: a 30-day supply of all necessary medications OR: call in a Rx to designated local community pharmacy at 555-5555] with 'For delivery to Operation Comfort)' in the message line. Operation Comfort cannot prescribe meds or refills."

[ ]  Patient’s current pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**☐** Confirm patient provided verbal consent to release health information to Alameda County

[ ]  Confirm patient verbally agreed to abide with quarantine/isolation period (Greater of 7 days since onset or 3 days post symptom resolution; For **Exposed** to Known COVID, 10 days.)

**I accept this person for transfer to Project Comfort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name Signature Date**

*----------------------------* ***END CALL AND REFER TO HOTEL NURSING STAFF****----------------------*