**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****----------------------*