**DSH INFECTIOUS DISEASE ADMISSION CLEARANCE MEMO**

To help ensure the health and safety of our patients and staff at DSH, we are requiring the below questions to be answered for each patient transferring to or returning to DSH. **This form MUST be received 2 days prior to the patient’s admission or the Friday before when the admission date is a Monday. The patient’s transport may be canceled if not received.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sending facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receiving facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee confirming information is accurate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Questions** | **Yes** | **No** |
| **1** | What is the patient’s temperature today? (list temp) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **2** | Has the patient had a fever above 100.4 F in the last 7 days? |  |  |
| **3** | Does the patient report or has been observed to have any symptoms such as:* Respiratory (sore throat, cough, nasal congestion, shortness of breath etc)
* GI (nausea, vomiting, abdominal pain, diarrhea etc)
* Flu-like (headaches, chills, fatigue, muscle aches etc)
* Other (skin lesion, rash, new loss of taste or smell etc)

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
| **4** | Does the patient have any underlying medical conditions? If yes list the medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **5** | Is the patient currently in isolation? (If yes, answer below)For what condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, start date: \_\_\_\_\_\_\_\_\_\_\_\_ Expected end date: \_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
| **6** | Is the patient currently on quarantine? (If yes, answer below)For what condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First date of exposure: \_\_\_\_\_\_\_\_\_\_\_\_Expected end date of quarantine:  |  |  |
| **7** | Has the sending facility had any confirmed or exposed cases of COVID-19 orother contagious infections in the past 10 days? Please specify if yes: |  |  |
| **8** | Has the patient had exposure to any persons with COVID-19 or other contagious infections in the past 10 days? (if yes, please elaborate below) |   |  |
| **9** | Has the patient been tested for COVID-19 in the past 7 days? If yes, date: \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_Testing is optional unless questions 2, 3, 6, or 8 were answered YES. Tests not performed within 7 days may be considered based on clinical discussion and determination of risk. |  |  |
| **10** | Has the patient received a COVID-19 vaccine? Date of 1st dose: \_\_\_\_\_\_\_\_\_\_ Brand: \_\_\_\_\_\_\_\_\_\_Date of 2nd dose: \_\_\_\_\_\_\_\_\_\_ Brand: \_\_\_\_\_\_\_\_\_\_Date of 3rd dose/booster: \_\_\_\_\_\_\_\_\_ Brand: \_\_\_\_\_\_\_\_\_\_ |  |  |
| **11** | Has the patient tested positive for COVID-19 in the last 90 days? If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **12** | Has the patient been exposed to MPX in the last 21 days? If yes, last date of exposure (and elaborate below): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **13** | Has the patient received a MPX vaccine? If yes, which brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of 1st dose:\_\_\_\_\_\_\_\_\_\_\_ Date of 2nd dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Additional information or comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_