COVID-19 DHS-ISOLATION SITES HOSPITAL REFERRAL

Clients Name (First, Last) _____ DOB: _____

Referral Source Name _____

Referral Source Type: Health care facility ◯; Alternate Site of Care ◯; Other _____

Person Completing the Referral_____ Contact Number _____

The DHS-Isolation Site Hospital Referral form must be completed for each patient referred to a DHS Isolation site and emailed to DHSMedical-COVID19@dhs.nyc.gov. Completion of this form will help the Department of Homeless Services (DHS) determine if the patient is medically appropriate for the level of services at the DHS Isolation Sites. DHS-Isolation sites are hotels for clients with mild COVID illness and no complicating factors who do not require medical or supportive or home care. DHS Isolation sites are not medical facilities.

Absolute Exclusion Criteria for DHS single adult shelter or safe haven If the patient has one or more of the health conditions, limitations of independent activities, or functional needs listed below, they are medically inappropriate for DHS single adult shelter or Safe Haven	
• Inability to care for self and independently manage activities of daily living; use the ADL Assessment Form included on the Referral Form. An ADL score <12 indicates medical inappropriateness for shelter. The ADL Assessment Form must be completed by a clinician on the patient's team; • Lack of decisional capacity; • Need for home care or visiting nurse services beyond wound care or IM/IV medication administration and beyond 2 weeks; • Severe immunosuppression (chemotherapy, end-stage AIDS, post-transplant, with an Absolute Neutrophil Count (ANC) <500mL); • Dementia or major cognitive deficits; • Inability to: understand spoken, signed, visual, or tactile language with or without an interpreter;	• Inability to make needs known or follow commands; • Poses imminent risk of physical harm to themselves or others; • Inability to independently manage chronic illnesses or medication administration, schedule, and reminders, including inability to self-administer insulin; • Inability to independently manage urinary catheters; • Peritoneal dialysis; • Inability to manage urinary or bowel incontinence or explosive diarrhea; • Oxygen-dependence requiring an oxygen tank/cylinder of any size, containing liquid or compressed oxygen; • Unresolved delirium; • Cranial Halo Devices or stabilizing protective gear worn continuously; or • On a ventilator.

If any of the above criteria are met, STOP, DO NOT REFER to DHS

In Addition, Given the COVID Illness, Do Not Refer to DHS Anyone with the Risk Factors or Conditions Below, Seek Alternate Placement

- Age>64 years
- Severe shortness of breath with respiratory rate >24 breaths per min
- O2 saturation <93% on room air
- Unstable or stable for <24 hours
- Serious mental illness or history of suicide ideation or attempt
- Untreated substance use disorder with overdose in last 30 days or recently left detox facility or prison/jail
- Require renal dialysis
- Uncontrolled heart disease, with low ejection fraction (<40%) with or without peripheral edema
- Severe lung disease, with poor baseline lung function and O2 sat<93% and requiring oxygen
- Severe liver disease, with coagulopathy (INR>2) or total bilirubin > 2.0 or abnormal ammonia level
- Uncontrolled diabetes (Hb A1C>8.0 and Fasting Blood Sugar >200 mg/dL)

- Obesity affecting respiratory or circulatory function or BMI >40, or BMI >35 if has other chronic medical conditions
- Immunosuppression (biologic or other immunosuppressive medications including chronic corticosteroid at ≥20 mg oral prednisone daily, HIV infection with CD4 count<200 cells/mm3) or other causes of immune deficiency
- Inability to perform one or more activity of daily living, requiring any assistance from another individual
- Inability to make one's needs known, such as from dementia (MMSE score <25) or stroke or developmental disability
- Require tube feeding, nebulizer or has central or PICC line
- Tracheostomy, colostomy or jejunostomy
- Anything that makes someone inappropriate for Javits or any Alternate Site of Care

Please Answer the Following Questions:

ACKNOWLEDGEMENT	YES	NO
Do you acknowledge the DHS Isolation Site has **LIMITED/NO** medical care?		
Do you confirm that the patient is at **LOW RISK** of complications and death?		
Do you affirm that the patient is appropriate for DHS Isolation Sites as they have **LIMITED**/**NO** medical care?		
COVID -19 SCREEN		
Test: Pending, positive, or not administered		
Date of symptom onset		
Date of last fever		

ACTIVITIES OF DAILY LIVING Assessment	Patient's Capacities	**Score (1/2/3)**
1. BATHING	1. Bathe self independently, including use of devices such as shower chair and/or grab bars 2. Need moderate assistance with bathing 3. Cannot bathe self independently and needs intermittent or constant assistance	
2. DRESSING	1. Independently retrieve all clothing, dress and undress including shoes and outer garments 2. Can dress independently with the exclusion of clothing that requires fine motor skills such as zippers, buttons, and/or tying shoes 3. Cannot dress independently and needs intermittent or constant assistance	
3. BOWELS	1. Control bowel functions without assistance 2. Manage bowels with catheter, colostomy bag, or diapers independently and without leaks 3. Cannot control bowels and needs intermittent or constant assistance	
4. BLADDER	1. Control bladder functions without assistance 2. Control bladder function with the use of diapers to control leaking or minimal incontinence 3. Cannot control bladder function, is incontinent and needs intermittent or constant assistance	
5. TRANSFER	1. Complete necessary transfers with no supervision or physical assistance	

	2. Complete transfers independently with equipment, such as railings, trapeze 3. Require intermittent or constant assistance for transfer	
6. EATING	1. Feed self without supervision or physical assistance 2. Feed self independently with the help of adaptive equipment, weighted tools, may require supervision or encouragement 3. Require intermittent or constant supervision, is totally fed by hand, receives or tube/parenteral feeding	
7. MOBILITY	1. Walk with no supervision or human assistance 2. Walk independently but require mechanical device, crutches, walker or wheelchair 3. Require supervision or physical assistance, rely on someone else to move about, if at all.	
8. COMMUNICATION	1. Communicate through spoken, signed, visual, or tactile language with or without an interpreter 2. Can communicate with assistance /prompts 3. Cannot communicate	
9. COGNITION	1. Understand directions and follow commands, and make needs known 2. Able to understand directions and follow commands with minimal assistance 3. Unable to understand directions and follow commands and make needs known	

HOSPITAL COURSE	**Yes**	**No**
Was the patient in the ICU		
Was the patient intubated (incl. date D/C intubation)		
Symptoms present on admission		

MEDICAL CONDITIONS/RISK FACTORS	Yes	No
65 yrs. Of age or Older		
Chronic Lung Disease		
Serious Heart Conditions		
Immunocompromised		
Describe immuno-compromised condition		
Severe Obesity		
Chronic Kidney Disease undergoing dialysis		
Chronic Liver Disease		
IF ANY YES TO ANY CONDITION, DHS MAY REQUIRE MORE INFORMATION		
Brief description of hospital course (include all symptoms and treatments related to COVID-19 and any other condition)		

DISCHARGE ASSESSMENT		
Last O2 Saturation on room air		
Latest Respiratory Rate		
Latest Heart Rate		
Latest Temperature (°F)		
Respiratory Status	YES (Y)	NO (N)
Patient still requires oxygen?		
Patient cannot complete a sentence without stopping for a breath		
Patient cannot walk more than 10 feet without stopping for a breath		
IF ANY YES TO RESPIRATORY STATUS, STOP: NOT ELIGIBLE FOR ISOLATION HOTEL: FIND ALTERNATE PLACEMENT		

MENTAL HEALTH SCREENING	Yes	No
Mental Health Diagnosis		
Substance Use Disorder	If yes, list substance:	
On Buprenorphine (Y/N)		
On methadone (Y/N)		

PATIENT SUICIDE PRE-SCREENING	YES	NO
In your lifetime, have you had thoughts of killing yourself?		
In your lifetime, have you attempted to kill yourself?		
In the past month, including today, did you have thoughts of killing yourself or attempted to kill yourself?		
IF ANY YES TO SUICIDE PRE-SCREENING QUESTIONS, STOP: NOT ELIGIBLE FOR ISOLATION HOTEL: FIND ALTERNATE PLACEMENT		

MEDICATIONS

DISCHARGE SUMMARY – present conditions for monitoring/treatment, cautions

Follow up appointments REQUIRED		
Are follow up appointments scheduled? Where and when	YES	NO
Name, email address and cellphone of referring clinician if referred by clinical, ED or inpatient hospital setting		
Name, email address and cellphone of referring social worker		