ISOLATION SITE REFERRAL

Clients Name (First, Last) _____ **DOB** _____

CARES ID, if known _____

Referral Source/Hospital Name _____

Referral Source:

Healthcare Facility ○ Alternate Site of Care ○ Other _____

Emergency Department ○ Inpatient Department ○

Person Completing the Referral_____**Contact Number** _____

This referral tool is intended to help you determine if your patient or client can be appropriately placed into the isolation hotel program to prevent transmission of COVID-19.

Even if a patient qualifies according to everything on this list, you must still make a clinical judgement as to whether this is the right setting for this person.

NOTE: The hotels **DO NOT** provide medical services. Clinical support staff will be onsite to monitor low-level health and social services condition and needs of hotel clients as appropriate, coordinate transfer of clients who need additional care for whatever reasons, and/or coordinate discharge.

The isolation hotels are only appropriate for people who are stable enough to isolate alone in a hotel room, similar to having a patient isolate alone at home.

1) Is this person a client of the Department of Homeless Services? (To check, call the DHS hotline at 212-361-5590)
   - Yes; if yes, email this completed form to DHSMedical-COVID19@dhs.nyc.gov
2) Does the person have any underlying illness or absolute contra-indications for this type of program as described in Appendix 1?
   - If yes, then NOT eligible.
   - If no, next question.
3) Will the person be able to independently complete activities of daily living without assistance? Before moving forward, complete the ADL screen below.

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	

Please Answer the Following Questions:

ACKNOWLEDGEMENT	YES	NO
Do you acknowledge the 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 Isolation Sites as they have **LIMITED/NO** medical care?		
COVID -19 SCREEN		
Test: Pending, positive, or not administered		
Test date		
Enter date of symptom onset		
Enter date of last fever		
HOSPITAL COURSE	YES	NO
Was the patient in the ICU?		
Was the patient intubated?		
If yes, incl. date intubation) discontinued		
Symptoms present on admission (please list)		

MEDICAL CONDITIONS/RISK FACTORS	YES	NO
65 yrs. of age or Older		
Chronic Lung Disease		
Serious Heart Condition		
Immunocompromised		
If yes, describe immuno-compromised condition		
Severe Obesity		
Chronic Kidney Disease undergoing dialysis		
Chronic Liver Disease		
IF ANY YES TO ANY CONDITION, REVIEWER 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	NO
Patient requires oxygen?		
Patient cannot complete a sentence without stopping for a breath		
Patient cannot walk more than 10 feet without stopping for a breath OR unable to wheel self > 10ft		
IF ANY YES TO RESPIRATORY STATUS QUESTIONS, STOP: NOT ELIGIBLE FOR ISOLATION HOTEL FIND ALTERNATE PLACEMENT		
MENTAL HEALTH SCREENING		
Mental Health Diagnoses (please list)		
SUBSTANCE USE DISORDER SCREENING	YES	NO
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 (please list):
DISCHARGE SUMMARY – present conditions for monitoring/treatment, cautions

Follow up appointments REQUIRED	YES	NO
Are follow up appointments scheduled?		
Where and when If not, include name and number of their PCP		
Name, email address and cellphone of referring clinician if referred by clinical, ED or inpatient hospital setting		
Name, email address and cellphone of referring shelter of other referring person		

Appendix I – Existing Absolute Criteria for Medical Inappropriateness for DHS Shelter

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 with a Higher Level of Care for the Duration of Isolation -- This is Temporary

Please Refer to Shelter a Day or Two Prior to End of Isolation

- 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
- 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
- Serious mental illness or history of suicide ideation or suicide attempt make a stay in an isolation hotel with minimal surveillance risky. Consider a supportive environment for persons with serious and persistent mental illness, who are not likely to observe isolation for the duration of isolation. One or two days prior to end of isolation, refer to DHS for mental health shelter bed.