Residential Referral Screening Tool

Client:_____

Operation & Home: _____Date:_____

Process:

1. Call: Referral Source or Guardian before proceeding with admission or visit
2. Ask: Please let us know if **the client or anyone in the home with client** have any of the following (check the appropriate box):

	Yes	No	Details/Notes
Fever greater than 100.0° F (37.8° C) in the past 14 days?			
One or more of the following: muscle aches, shortness of breath, sore throat, new or changed cough, chills, headache, loss of taste or smell (new onset in the past 14 days)?			
Recent pneumonia or flu infection?			
Have traveled internationally or on a cruise ship within the last 14 days?			
Contact with someone who has confirmed or suspected COVID-19 (Coronavirus) within the last 14 days?			
Has the Client been hospitalized recently? If so, for what reason?			
What are the Client's primary diagnoses?			
Are they considered immunosuppressed due to an ongoing/chronic condition or treatments?			

3. Meet-**Contact Director of Clinical Practice** to review information and Operational Leaders and DON/Lead Nurse to meet and discuss any needed precautions or any further steps needed to admit client.