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| --- | --- | --- |
| **DATE:** | **HOSPITAL CASE MANAGER NAME:** | **PHONE:** |
| **Check if High Priority (ie patient unable to appropriately isolate upon discharge)**  ***Note “High Priority” in the subject line of the email when submitting this form*** | | |
| **Patient Demographics** | | |
| **Patient Name** |  | **DATE OF BIRTH** |
| **Address** |  | **PHONE** |
| **Language** |  | **NEXT OF KIN / PHONE** |
| **Payer source** |  | **HPSM MEMBER? YES / NO** |
| **covid history** | | |
| **COURSE** | **Hospital Admit Date:**  **Comorbidities:**  **IMMUNOCOMPROMISED?: YES / NO**  (immunocompromised, pregnant, dialysis) | **Admitting Symptoms:**  **Resolved? Improving?** |
| **SYMPTOM ONSET** | **Onset Date:** | **Symptoms at Onset:** |
| **VACCINATION STATUS** | **Vaccine Name:** | **Dose #1 Date:**  **Dose #2 Date:** |
| **COVID19 TEST** | **Date(s)/Result(s): CT VALUE:** | **Test Result Attached: YES / NO** |
| **FEVER-FREE > 24 HRS** | **Last Fever (>100.4F/>38C) Date/Temp:** | **Today’s Temp:**  **Last Use of Fever Reducing Rx:** |
| **ISOLATION NEEDS** | **Hospital-Calculated Isolation Period Ends:** | **Understands & able to safely isolate at home?** |
| **discharge plan / Isolation Needs** | | |
| **DISCHARGE** | Medically Cleared ☐Yes ☐No  Today ☐ Tomorrow  Pt has already been discharged | |
| **DISCHARGE DESTINATION** | Home (# of Bed/Baths) \_\_\_\_\_\_/\_\_\_\_\_\_ # of persons in home: \_\_\_\_\_\_\_  SNF, LTC, ARU, Sub-Acute, B & C, ALF (Facility Name & Contact Info) \_\_\_\_\_\_\_\_\_\_\_  Homeless  Hotel Placement is Needed | |
| **special needs** | Home O2  Home Health Service  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Renal Dialysis (Schedule: Sun Mon Tues Weds Thurs Fri Sat) | |
| **vulnerable persons at home** | > 65 years of age  <5 years if age  Pregnant / < 2 wk Post-Partum  Immunocompromised  Heart, Lung or Kidney Dx  Hospice | |
| **TRANSPORTATION** | How is patient being transported? | |