ACM DOCUMENTATION FORM
Discharge Planning COVID-19 Screen

Affix patient label

Criteria for 2019 Novel Coronavirus Discharge Screen

1.	The patient is considered a "Person Under Investigation" (PUI) for COVID-19	❑ Yes	❑ No
2.	The patient been confirmed as positive for COVID-19	❑ Yes	❑ No
3.	Patient is being discharged with Home Care Services/Home Hospice	❑ Yes	❑ No
4.	Did the patient meet criteria for testing?	❑ Yes	❑ No

Guidance for Discharge to Home/Home with Home Care/Home Hospice Assessment and Patient Education

1.	The patient is stable enough to receive care at home.	❑ Yes	❑ No
2.	Appropriate caregivers are available as needed.	❑ Yes	❑ Not Applicable
3.	As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available.	❑ Yes	❑ No
4.	Resources for access to food and other necessities are available.	❑ Yes	❑ No
5.	If patient is being discharged on anticoagulant, delivery address has been verified and if different than registration, task sent to Pharmacy.	❑ Yes	❑ No
6.	The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)?	❑ Yes	❑ No
7.	There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions) *see Care Coordination Progress Notes	❑ Yes implement escalation*	❑ No

Guidance for Covid-19 Negative Patients Being Discharged Home Who Require Home Care Services

1.	Do any household members meet the screening criteria for COVID-19 testing?	❑ Yes, contact Home Care/Hospice ❑ No, routine discharge

Screening Criteria for Discharge to Post-acute Facility

1.	The patient is stable enough to receive care at home.	❑ Yes	❑ No
2.	Appropriate caregivers are available as needed.	❑ Yes	❑ Not Applicable
3.	As much as possible, instructions to stay in a specific room and away from other people in the home. Also, instructions to use a separate bathroom, if available.	❑ Yes	❑ No
4.	Resources for access to food and other necessities are available.	❑ Yes	❑ No
5.	The patient and other household members have access to appropriate, recommended personal protective equipment (at a minimum gloves and facemask) and are capable of adhering to precautions recommended as part of home care or isolation (e.g. respiratory hygiene and cough etiquette, hand hygiene)?	❑ Yes	❑ No
6.	There are household members who may be at increased risk of complications from 2019-nCoV infection (e.g. people > 65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions) *see Care Coordination Progress Notes	❑ Yes implement escalation*	❑ No
7.	It has been at least seven days since the initial positive test for COVID-19	❑ Yes	❑ No
8.	Resolution of fever, without use of antipyretic medication	❑ Yes	❑ No
9.	Improvement in illness signs and symptoms	❑ Yes	❑ No
10.	Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of nasopharyngeal swabs specimens collected 24 hours apart.	❑ Yes	❑ No

Discharge Disposition Plan/Location

❑	Home/Home with Homecare/ Home Hospice services positive COVID19 patient		
	COVID-19 Patient education materials provided	❑ Yes	❑ No
	Personal Protective Equipment (PPE) pack provided	❑ Yes	❑ No
	Certified Home Health Agency notified via warm handoff, if applicable	❑ Yes	❑ No
	Post discharge address verified and communicated to Pharmacy (if applicable)	❑ Yes	❑ No
❑	Home/Home with Homecare/ Home Hospice services for COVID19 negative patient with COVID19 positive household member		
	COVID-19 Patient education materials provided	❑ Yes	❑ No
	Personal Protective Equipment (PPE) pack provided	❑ Yes	❑ No
	Certified Home Health Agency notified via warm handoff, if applicable	❑ Yes	❑ No
❑	Home with Home Care routine discharge		
❑	Post-Acute Facility		
	Sent documentation of criteria met with referral	❑ Yes	❑ No
	Post-Acute receiving facility contacted to provide warm handoff	❑ Yes	❑ No

Staff Information

Print Name: _____ Title: _____

Signature: _____

Date/Time: _____ Phone Number: _____

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