COVID-19 Nursing Home Communication Form

Patient Name: _________________________ Nursing Home Name: _________________________

Facility Contact Name: _________________________ Contact Phone Number: ________________

Patient’s current symptoms (check all that apply):
☐ Cough   ☐ New or worsening shortness of breath   ☐ Fever   ☐ Chills   ☐ Muscle pain   ☐ Sore throat
☐ New loss of taste or smell   ☐ Headache   ☐ Nausea   ☐ Vomiting   ☐ Diarrhea   ☐ None of the above

Patient’s Maximum Temp in past 24 hours: ________

Patient’s COVID-19 Status: Please circle appropriate category

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
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| COVID-19 Vaccination Yes:______  No:_______ | 1st Dose Date: ____/____/____  2nd Dose Date: ____/____/____  
Vaccine Manufacture: ______________________________ |
| Healthy / No known exposure     | No symptoms, no close contact with confirmed/suspected COVID-19 case, and no outbreak at the facility                                      |
| Asymptomatic PUI                | No symptoms but close contact with confirmed/suspected COVID case or outbreak at the facility                                           |
| Symptomatic PUI                 | Showing symptoms (fever, cough, short of breath) plus close contact with confirmed/suspected COVID case                                  |
| COVID Positive                  | Tested positive for COVID-19 but symptoms do not warrant hospitalization                                                                |
| COVID Recovered (CDC symptom-based guidance 7-17-2020) | • Fever free (without fever-reducing medications) for at least 24 hours and improvement in symptoms (e.g., cough, shortness of breath) and at least 10 days have passed since symptoms first appeared, OR  
• Resolution of fever (without fever-reducing medications) and resolution of symptoms; and negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) |
| COVID-19 Testing Status         | □ Positive   ☐ Negative   ☐ Pending   Date: ____/____/____  Time: ____:____  □AM  □PM  
☐ Not Tested

Additional information: Please provide any additional information /concerns you would like the dialysis facility to know about this resident.

This form was created using materials developed by Paul Palevsky, MD with the University of Pittsburgh and Sid Shah, MD with the University of Pennsylvania Health System along with revisions from the ESRD Network 8. We gratefully acknowledge their work and sharing of these resources with The Forum of ESRD Networks.

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