## Risk Assessment Worksheet

- Discharging/Transferring site completes page 1
- Receiving Unit/Site/Facility completes page 2 *(this can be done by phone or fax in collaboration with the discharging site)*

### Discharging/Transferring Unit/ Site/ Facility

<table>
<thead>
<tr>
<th>Zone:</th>
<th>Date of Request (yyyy-Mon-dd):</th>
</tr>
</thead>
</table>

**Patient/Resident Name** *(Last, First):*

<table>
<thead>
<tr>
<th>PHN/ULI:</th>
<th>Date of Birth (yyyy-Mon-dd):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Date of Admission (yyyy-Mon-dd):</th>
</tr>
</thead>
</table>

**Reason for Admission:**

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Phone Number:</th>
</tr>
</thead>
</table>

Is discharging unit/site under Outbreak precautions?

- [ ] No
- [ ] Yes →

  **EI# (if required/available):**

  **Onset date (yyyy-Mon-dd):**

  **Etiological/Agent type:**

Attending physician approves of pending discharge/transfer to a site with an outbreak?

- [ ] No
- [ ] Yes
- [ ] N/A

Informed consent obtained from patient/resident or guardian for discharge/transfer to site with an outbreak?

- [ ] No
- [ ] Yes
- [ ] N/A

Symptoms of outbreak illness in patient/resident *(ONLY complete if patient is coming from an outbreak unit/site)*

- [ ] No *(never symptomatic for outbreak illness)*
- [ ] Yes →

  **Onset date (yyyy-Mon-dd):**

  **Resolved date (yyyy-Mon-dd):**

  **Describe symptoms:**

For **confirmed influenza outbreaks** only *(at sending or receiving site):* Immunization and/or antiviral prophylaxis

Has the patient/resident received current season influenza vaccine?

- [ ] No →

  **Provide vaccine for patient/resident prior to discharge.**

- [ ] Yes →

  **Date of immunization (yyyy-Mon-dd):**

Has the patient/resident commenced antiviral prophylaxis?

- [ ] No →

  **For influenza outbreak at receiving site, provide first dose of antiviral before transfer.**

- [ ] Yes →

  **Start date (yyyy-Mon-dd):**

**Related comorbidities** *(e.g., cardiovascular, renal disease, respiratory, immunocompromised, pregnancy):*

**Cognition and compliance with recommended hygiene** *(Choose One)*

- [ ] Independent and compliant
- [ ] Compliant but requires prompting *(needs to be monitored)*
- [ ] Non-compliant, mobile
- [ ] Non-compliant, mobile with assistance *(walker, wheelchair, personal assistance)*
- [ ] Non-compliant, non-mobile *(bed-ridden)*
## Risk Assessment Worksheet

### Receiving Unit/ Site/ Facility
*(To be completed by or in collaboration with the receiving unit/site/facility)*

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Room Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact Name <em>(Person completing form):</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone number:</th>
<th>Fax number:</th>
</tr>
</thead>
</table>

Receiving site/unit in agreement with patient/resident transfer/admission:
- [ ] No
- [ ] Yes

Patient/Resident is being admitted to outbreak unit:
- [ ] No *(outbreak information below not required)*
- [ ] Yes *(outbreak information required as listed below)*

### Outbreak Onset date *(yyyy-Mon-dd):*

Outbreak symptoms *(list):*

| ____________________________________________________________ |
| ____________________________________________________________ |

All outbreak control measures in place:
- [ ] No
- [ ] Yes

Able to isolate/confine patient/resident to single room *(if required)*:
- [ ] No
- [ ] Yes

Able to carry out enhanced disinfection of room for remainder of outbreak *(if required)*:
- [ ] No
- [ ] Yes

Able to provide tray service to client in room *(if required)*:
- [ ] No
- [ ] Yes

The following actions must be completed for confirmed influenza A or B outbreaks:
- [ ] Arrangements made to continue antiviral prophylaxis, as required.
- [ ] Confirm that current season influenza vaccine has been/will be given prior to discharge *(unless refused)*.

### Transfer/Discharge Review *(To complete as per zone processes)*

#### Transfer/Discharge
- [ ] Approved
- [ ] NOT Approved

<table>
<thead>
<tr>
<th>Name of MOH:</th>
<th>Date <em>(yyyy-Mon-dd):</em></th>
</tr>
</thead>
</table>

### Outbreak Lead completing form *(if applicable)*

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date <em>(yyyy-Mon-dd):</em></th>
</tr>
</thead>
</table>

Notes/Instructions:

| ____________________________________________________________ |
| ____________________________________________________________ |
| ____________________________________________________________ |
| ____________________________________________________________ |