Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)	

Patient Transfer/Discharge Questionnaire

This screener is to be completed for patients transferring to a continuing care home from acute care or community. It is to be **completed as close to transfer/discharge as possible (within 4 hours).** The form is to remain part of the individual's permanent health record.

A positive response to questions 1 - 3 does not exclude the individual from transfer/discharge. Decisions about safety precautions and isolation requirements upon transfer will be made in collaboration with the receiving site, based on recommendations in the applicable outbreak guide in conjunction with a Risk Assess-ment Worksheet *(form 19669)*.

For concerns or questions, reach out to the accountable leader, zone MOH or designate.

Any person who is a confirmed case of any communicable disease must follow isolation requirements as per recommendations in the applicable outbreak guide.

1. Have you had any known close contact* with a confirmed case of any communicable disease in the last 10 days?

☐ No ► Proceed to Question 2.

☐ Yes ► Refer to outbreak prevention and control guidelines for management of close contact.

* **Close Contact** means any person suspected to have been exposed to an infected person or a contaminated environment to a sufficient degree to have had the opportunity to become infected or colonized with an organism.

2. Do you have any new onset *(or worsening)* of the following symptoms in the last 10 days?

☐ No ► Proceed to Question 3.

☐ Yes ► If you answered YES to any symptom, client must isolate in their room/home and follow outbreak prevention, control and management requirements applicable to the care area and immunization status.

For respiratory symptoms, use the Respiratory Illness Assessment for Albertans to determine if testing is recommended. Follow information on isolation recommendations.

Indicate presence of symptom(s) by placing check marks ✓ in "Yes" or "No" boxes

Symptoms	Yes	No	Symptom	Yes	No
Fever *Fever may not be prominent in those 65 years of age and older.*			Decrease in oxygen saturation level or increased oxygen requirements		
Cough			Nasal congestion/stuffy nose		
Shortness of breath/difficulty breathing			Feeling unwell/fatigued/severe exhaustion		
Runny nose			Nausea/vomiting/diarrhea		
Sore throat			Loss of sense of taste or smell		
New rash					

3. Have you tested positive for any communicable disease in the last 90 days?

☐ No ☐ Yes ► Name of infectious agent _____

Date of positive test *(dd-Mon-yyyy)* _____

Completed By	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Ensure to document any changes in close contact status, symptoms and test results on the Inter-Facility Patient Transfer Form #09277.