

Infection Control Communication Form

Between Nursing/Personal Care/Assisted Living Facility and Dialysis Facility

Side 1: LTCF Communication to Dialysis Facility

Patient Name: _____ **Date of Birth:** ___/___/___
LTCF Name: _____ **Unit Phone Number:** _____
Dialysis Facility Name: _____ **Dialysis Phone Number:** _____

Patient's current symptoms when leaving for dialysis (check all that apply):

- Temp >99 F
 Chills
 Cough
 New or worsening shortness of breath
 Fatigue
 Headache
 Muscle pain or body aches
 New loss of taste or smell
 Sore throat
 Rhinorrhea
 Nausea or vomiting
 Diarrhea
 None of the above

Patient's Infection Control Status:

Status	Definition
<input type="checkbox"/> Unexposed/Healthy	No symptoms, no close contact with confirmed/suspected COVID-19 case, and no positive case at the living facility
<input type="checkbox"/> Exposed	<input type="checkbox"/> COVID-19 <input type="checkbox"/> Influenza <input type="checkbox"/> RSV <input type="checkbox"/> Other _____
<input type="checkbox"/> COVID-19 Positive	Positive Test Date ___/___/___ Date of Exit from Isolation ___/___/___
<input type="checkbox"/> Influenza/RSV Positive	Positive Test Date ___/___/___ Date of Exit from Isolation ___/___/___
<input type="checkbox"/> Active Contact Precaution	<input type="checkbox"/> C. difficile <input type="checkbox"/> VRE <input type="checkbox"/> Other MDRO <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Other _____

COVID-19 and Influenza Vaccination Status:

COVID-19

- Complete
 Partial (1 dose of 2-dose series)
 Not vaccinated
 Boosted
 Vaccine 1st Dose:
 2-Dose (Moderna or Pfizer)
 1-Dose (J & J):
 Date: ___/___/___
 Vaccine 2nd Dose (if applicable):
 Date: ___/___/___
 BiValent Booster Dose:
 Yes
 No
 Date: ___/___/___

Influenza

Influenza Vaccine:
 Yes
 No
 Date: ___/___/___

Patient status unchanged (if patient or facility status changed, new form must be completed):

Date: ___/___/___
 Init: _____
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Infection Control Communication Form
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Side 2: Dialysis Facility Communication to LTCF

Patient's current symptoms when returning from dialysis (check all that apply):

- Temp >99 F Chills Cough New or worsening shortness of breath
 Fatigue Headache Muscle pain or body aches New loss of taste or smell Sore throat
 Rhinorrhea Nausea or vomiting Diarrhea None of the above

New Patient Exposures or Change in Infection Control Status in Dialysis

Status Change	Definition
<input type="checkbox"/> Unexposed/Healthy	No symptoms, no close contact with confirmed/suspected COVID-19 case, and no positive case at the living facility
<input type="checkbox"/> Exposed	<input type="checkbox"/> COVID-19 <input type="checkbox"/> Influenza <input type="checkbox"/> RSV <input type="checkbox"/> Other _____
<input type="checkbox"/> COVID-19 Positive	Positive Test Date ___/___/___ Date of Exit from Isolation ___/___/___
<input type="checkbox"/> Influenza/RSV Positive	Positive Test Date ___/___/___ Date of Exit from Isolation ___/___/___
<input type="checkbox"/> Active Contact Precaution	<input type="checkbox"/> C. difficile <input type="checkbox"/> VRE <input type="checkbox"/> Other MDRO <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Other _____

Patient status unchanged (if patient or dialysis unit status changed, new form must be completed):

Date: ___/___/___ Init: ___ Date: ___/___/___ Init: ___ Date: ___/___/___ Init: ___
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**IF PATIENT DEVELOPS ABOVE SYMPTOMS,
 OR HAS COVID EXPOSURE DURING DIALYSIS TREATMENT, LTCF MUST BE NOTIFIED BY
 PHONE BEFORE PATIENT LEAVES DIALYSIS**