Referral Form for COVID19 Isolation and Quarantine Facility No 1 (Byron Street, Bellingham)

Applicant Information

Name: ____

Date of Birth: __________________

Cell Phone Number (*indicate if text only*): ___________________________

Emergency Contact (*if any*): ____

Contact Info: ____

This form completed by:

Contact Info: ____

Primary Care Provider (Indicate GRACE if not assigned to a provider)

PCP Name: ____

PCP Agency: ____

Contact Info: ____

PCP has been notified?

- o **Yes**
- o **No**

Community Agency Information *(e.g., Shelter, other Housing, CORS, HOTeam, Compass, Cascade Medical, GRACE, other. Star (*) individuals identified as primary information and support).* **Include contact information. PCP's offices may call these agencies to assist in completing behavioral health or housing sections of this form once the ROI is signed. Facility staff are available for consult at 360-592-7511. Complex referrals are likely to be a team effort.**

____

____

____

____

Health Insurance Information *(indicate none if uninsured)*

Insurance Carrier: ____

ID #: ____

Provider One verification attached.

- o **Yes**
- o **No**

Applicant Health History

Name:____

Date of Birth:____

COVID Status:

1) **Individual was exposed to a confirmed case of COVID-19 and is:**
   - ☐ Currently asymptomatic
   - ☐ Currently symptomatic
2) **Individual developed symptoms consistent with COVID on** (Date)_______________
3) **Symptoms included (check those that apply):**
   - ☐ Fever of 100.4 or greater
   - ☐ Cough
   - ☐ Shortness of breath
   - ☐ Headache
   - ☐ Muscle aches
   - ☐ Nausea/vomiting/diarrhea
   - ☐ Other __________________________________
4) **COVID test status is:**
   - ☐ Not yet tested
   - ☐ Tested on (Date) ________ by (Testing Agency)______________

5) **Test results are:**
   - ☐ Pending
   - ☐ Negative
   - ☐ Positive

6) **Recommendation is:**
   - ☐ Quarantine
   - ☐ Isolation

Home Health Needs:

Applicant is a candidate for Home Health referral to support COVID symptom monitoring?

- ☐ Yes
- ☐ No
- ☐ Other ____

If Yes, has PCP been notified to arrange Home Health?

Independent ADLs

Is the Applicant able to:

- ☐ Ambulate indendently
- ☐ Dress, bath, eat independently
- ☐ Take own medications independently

Other Health Issues: (Must be self-managed)

____

____

____

____

____

Current Medications:

____

____

Medication Allergies: *(indicate none if no known allergies)*

____

Behavioral Health Status (Information to be used to support applicant needs at the housing facility)

1) Does Applicant have a known history of Substance Use Disorder and/or Mental Health Disorder? ______________________________
2) Is Applicant an Active Drug User? ______________________________
3) Is Applicant interested in or receiving Medication Assisted Treatment? ______________________________
4) Sharps container or syringe exchange?

Transportation Needs:

Applicant will need transportation to the facility?

- ☐ Yes (Cabulance)
- ☐ No
- ☐ Other ______________________________

Medication Pick-up Needs

Applicant will need medication pick-up en route to Facility?

- ☐ Yes (Name of Pharmacy/Location) ______________________________
- ☐ No

COVID Testing Needs

Applicant needs to have COVID test arranged through Whatcom County Health Department drive-through testing (360-778-6100)?

- ☐ Yes
- ☐ No

Have the following forms been completed with the applicant to be sent to Bed Control at SJMC with this completed form?

- ☐ Release of Information
- ☐ Code of Conduct
- ☐ Voluntary Quarantine Isolation Agreement

Special Needs:

- Dietary Needs
  - ☐ Diabetes ____
  - ☐ Celiac Disease/Gluten ________________________________
  - ☐ Food Allergies______________________________________
  - ☐ Other ____
- Cell Phone/Electronic Device Access Needs
  - ☐ ____
- Recreational/Leisure Needs
  - ☐ ____
- Other Needs
  - ☐ ____
  - ☐ ____
  - ☐ ____

Additional Notes:

____

____

____

____

____

____

____

WHEN THIS FORM IS COMPLETED, CALL BED CONTROL AT PEACEHEALTH ST JOSEPH MEDICAL CENTER. THEY WILL MOVE THE REFERRAL FORWARD AND CONTACT THE FACILITY DIRECTLY. Phone: 360-788-8163. Fax: 360-715-4118.