Haliburton, Kawartha, Pine Ridge District Health Unit

Risk Assessment for Returning/Transferring a Patient into a Facility Experiencing an Outbreak

Use this form to determine if the patient can return to a facility experiencing an outbreak.

Instructions: Process should be completed within 24 hours of initiation.

Step 1: Hospital to complete Section A and fax/email it to the Facility where the patient is to return.

Step 2: Facility to complete Sections B and indicate in Section C if it is agreeable to repatriate, then fax/email to the hospital where the resident is admitted.

Step 3: If repatriation is mutually agreed upon, LTCH/RH staff contacts hospital to discuss date and time for repatriation and completes the appropriate fields in Section C. Health Unit does not need to be notified.

Step 4 (optional): Facility or hospital staff can request a consultation from the Health Unit by checking the appropriate box in Section C and faxing form to the Health Unit. **A request can be made during regular business hours (Monday-Friday, 0830-1630) at 1-866-888-4577 x 1232 or via fax at 905-885-9554.** An Outbreak Investigator will review the information provided in Sections A and B, and the Health Unit outbreak record, and provide a recommendation to the Facility and the Hospital. This recommendation can then be considered by Hospital and Facility staff in the repatriation decision making process. Revisions to the repatriation plan may also be suggested by the Health Unit. If the Facility and Hospital revise the decision to repatriate, return to Step 3.

SECTION A – Hospital

Name and title: Unit/department: Unit is in Outbreak: ☐ Yes ☐ No	Hospital: Phone number:
Date (YY/MM/DD):	Fax number:
Patient's ID number: Patient's initials:	Date of Birth (YY/MM/DD):
Date of planned discharge from hospital to facility (YY/MM/DD)?	
Will this patient be a new admission into the facility?	☐ Yes ☐ No
Does the patient's attending physician at the hospital agree to the admission/return based on a review of the current health status and the outbreak situation at the receiving facility?	☐ Yes ☐ No
What special care/level of care will this patient require upon return to the facility that was not required prior to hospital admission?	

Repatriation plan – The following measures will be done prior to return to facility to protect the resident from illness during this outbreak (check those that apply):

☐ Hospital staff have discussed the outbreak situation, and risks and benefits of repatriation/admission to facility during an outbreak situation with the resident/resident's substitute decision maker, and obtained informed consent.

☐ If the outbreak organism has been identified as influenza A or B, antivirals have been provided to the patient.

☐ Proposed date and time for repatriation to LTCH/RH: _____

SECTION B – Facility

Name and title: Unit/department: Date (YY/MM/DD):	Facility: Phone number: Fax number:
What is/are the causative agent(s) of the outbreak?	
What is the attack rate to date?	Residents ____ Staff ____
Are cases located throughout the facility or localized?	

Is transmission still occurring? If yes, onset date of the last case? (YY/MM/DD)	☐ Yes ☐ No
What is the approximate duration of illness?	
Percentage of cases, as of this date, hospitalized related to outbreak illness?	
Percentage of outbreak-related deaths, as of this date?	
Are cases experiencing severe symptoms (e.g. pneumonia)? If yes, percentage of cases, to date, with severe symptoms?	☐ Yes ☐ No
Would this resident be returned/admitted to an area where there is/are case(s)?	☐ Yes ☐ No
If facility is experiencing an influenza or COVID outbreak, has the patient been immunized?	☐ Yes ☐ No
COVID immunization (number of doses): Date of Last Dose:	
What are the concerns about admitting/repatriating this patient to your facility (e.g., staffing capacity, meeting patient's care needs, protecting patient from transmission of infection, patient's susceptibility to complications from infection, etc.)?	
Repatriation plan – What outbreak measures will be implemented if the resident returns to the facility, to prevent illness during this outbreak?	
SECTION C - Repatriation Plan	
☐ Facility agrees to repatriate based on the above information. ☐ Facility does not agree to repatriation based on the above information. ☐ Facility requests Health Unit consultation.	☐ Hospital requests Health Unit consultation. ☐ If facility agrees to repatriation, date, and time for repatriation that hospital and LTCH/RH have agreed upon: Date: _____ Time: _____
Signature:	Signature:
Title:	Title:
SECTION D (if required) – Health Unit: HKPR District Health Unit	
Name and title: Date (YY/MM/DD):	Phone number: Fax number:
Public Health Recommends: ☐ Return/admit into the facility (provided conditions listed under comments are met) ☐ DO NOT return/admit into the long-term care home at this time **Comments:** Signature:	
Have previous requests for this patient been submitted? ☐ Yes ☐ No If yes, date:	

Hospital ID number: _____

Any personal and personal health information that you may provide on this form is collected under the authority of relevant legislation including: the Health Protection and Promotion Act, as amended, the Regulated Health Professions Act, the Immunization of School Pupils Act, and the Personal Health Information Protection Act. This information will be used for assessment, management, treatment and reporting purposes. Your information may be shared within the Health Unit and as required by legislation. For information about the collection, use and disclosure of your information, please refer to the Health Unit website at www.hkpr.on.ca or contact the Medical Officer of Health, 200 Rose Glen Road, Port Hope, Ontario, L1A 3V6 or 1-866-888-4577.