Los Angeles County Department of Public Health
Isolation and Quarantine Referral Form
Persons Under Investigation and Stable COVID 19 + Individuals

REFERRING PROVIDER AND AGENCY INFORMATION

NAME: _____ **PHONE:** _____ **ID#** _____

REFERRING AGENCY: _____

REFERRING PROVIDER: _____ **PHONE:** _____

PATIENT LOCATION PRIOR TO TRANSPORT: _____ **DATE:** _____

VETERAN STATUS

Is the client a Veteran? ☐ Y ☐ N
If yes, is the client eligible for VA Healthcare Benefits? ☐ Y ☐ N
If yes to both questions, email COVID-19 B214 ADM-COMM form to referring provider for COVID-19 VA Housing

PATIENT DEMOGRAPHIC & CONTACT INFORMATION

Please provide the following demographic & contact information:

First Name	Last Name	DOB	Gender
			❑ M ❑ F ❑ TM ❑ TF ❑ Other

Local Address or where there stay in community	City ❑ Los Angeles	State ❑ CA	Zip

Home/Cell Phone: ❑ Text Msg Ok	Preferred Language	SSN	Medi-Cal/Insurance	Medical Record #

Medical Provider Name/Number	Mental Health Provider Name/Number	Case Manager Name/Number	Emergency Contact Name/Number

Housing Status **Please choose from options Below:**

☐ **Unsheltered and Unable to Self-Isolate** – *persons experiencing homelessness living in an encampment, on the streets or another place not meant for human habitation who cannot safely isolate.*

Congregate Housing (shelter, interim housing, board and care, etc.):

☐ In a facility with **shared sleeping space, shared bathrooms**, and unable to isolate from asymptomatic people.

☐ In a facility with private sleeping space **but cannot have separate bathrooms** for symptomatic and asymptomatic people

☐ In a facility with **shared space but can isolate sleeping and bathroom** facilities between symptomatic and asymptomatic people

☐ **Unsheltered but Able to Self-Isolate** (e.g. has a tent, capacity to practice social distancing, and access to supplies like food and medicine)

☐ **Has Home** (A housed person unable to safely self-isolate due to inability to access supplies like food and medicine or very high likelihood of infecting other household residents who are at high-risk of severe complications)

Additional notes:

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Vital Signs

Temperature	Respiratory Rate	Heart Rate	Blood Pressure	Oxygen Saturation

Height: _____ **Weight:** _____

Allergies

Allergies to medications? _____ ☐ Y ☐ N ☐ DK

Allergies to food? _____ ☐ Y ☐ N ☐ DK

Symptoms Check List

Does the individual appear sick? ☐ Y ☐ N ☐ DK
If yes, please provide specifics:

_____

Is the individual having respiratory difficulty? ☐ Y ☐ N ☐ DK

Is the individual experiencing confusion or lethargy? ☐ Y ☐ N ☐ DK

Does this person have complex medical problems that require continual nursing care? ☐ Y ☐ N ☐ DK

_____

Does this person require oxygen? ☐ Y ☐ N ☐ DK

Is this person able to climb stairs independently? ☐ Y ☐ N ☐ DK

Is this person able to follow directions and take care of himself/herself while in isolation?
☐ Y ☐ N ☐ DK
Is this person continent of urine and stool? ☐ Y ☐ N ☐ DK

COVID testing

Has the individual been tested for COVID-19? ☐ Y ☐ N

When were they tested? _____ ☐ PH Lab ☐ Quest ☐ Lab Corps

What was the result (if available)? ☐ - ☐ + ☐ DK

If the patient has not been tested:

Is the person experiencing COVID-19 like symptoms:

☐ Fever ☐ Cough ☐ Difficulty breathing

Was the individual exposed to a COVID-19 individual? ☐ Y ☐ N ☐ DK

How many days ago did the person first develop symptoms? _____

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Physical Health

What are the client's medical problems:

_____

Do they require dialysis? ☐ Y ☐ N ☐ DK

Does this person have at least a 14-day supply of their medications? ☐ Y ☐ N ☐ DK

_____

_____

Behavioral Health

To your knowledge, does the individual use substances (e.g.,opiates, meth, alcohol, or other drugs)?

☐ Y ☐ N ☐ DK _____

If yes, do they receive medication assisted treatment? ☐ Y ☐ N ☐ DK

If yes, do you anticipate they will have withdrawal symptoms if they do not access their drug of choice? ☐ Y ☐ N ☐ DK

Does the individual smoke tobacco or marijuana? ☐ Y ☐ N ☐ DK

To your knowledge, does the individual have a mental health diagnosis? ☐ Y ☐ N ☐ DK

What is the mental health diagnosis? _____

When was the last dose of injectable medication (if applicable and known): _____

Assistance with daily activities

Does the individual need assistance with daily activities? ☐ Y ☐ N ☐ DK

If yes, please specify:

☐ Eating
☐ Getting dressed
☐ Bathing
☐ Using the toilet
☐ Taking Medicine
☐ Other _____

Does the individual have a wheelchair? ☐ Y ☐ N

Does the individual have any disabilities (hearing/visual/speech impairments)? ☐ Y ☐ N

_____

Does the individual have any disabilities that require a caretaker? ☐ Y ☐ N

If yes, will a caretaker accompany the client? ☐ Y ☐ N

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Pets

Does the individual have any pets? ☐ Y ☐ N

Is the pet a designated service animal? ☐ Y ☐ N

Housing needs

Total number of individuals needing housing (for family members or caretakers): _____

Name(s) of family members: _____

Name(s) of caretaker(s): _____

Transportation needs

Does the individual need transportation to the housing site? ☐ Y ☐ N

When will they be ready to move to the housing site (date/time): _____

Other needs

Does the individual have belongings that need to be stored? ☐ Y ☐ N

Does the individual have a car or vehicle that needs to be stored? ☐ Y ☐ N

Additional notes

FOR REFERRALS MADE BY HEALTH CARE, HOMELESS SHELTERS AND SERVICE AGENCIES, AND LAW ENFORCEMENT

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FOR INTAKE COORDINATOR ONLY

INTAKE COORDINATOR INFORMATION
NAME: _____ PHONE: _____
REFERRAL COMPLETED: ☐ Y ☐ N ☐ PENDING
IF NO OR PENDING, WHY:_____
DATE THAT REFERRAL AND TRANSFER WAS COMPLETED:_____

Condition of Individual

Will the individual need isolation or quarantine? ☐ I ☐ Q

Housing Site Identified: _____

Housing Site Contact Name & Number: _____

Transportation Identified: ☐ Y ☐ N

Transportation Contact Name: _____