

## **Risk Assessment Worksheet**

- Refer to Risk Assessment Algorithm before completing form
  Discharging/Transferring site complete page 1
  Receiving Unit/Site/Facility completes page 2 (this can be done by phone or fax in collaboration with the discharging site)

Discharging/ Transferring Unit/ Site/ Facility  Patient/Resident Name (Last, First)  PHN/ULI  Date of Birth (dd-Mon-yyyy)  Discharging Unit Facility Name  Date of Requested for Transfer (dd-Mon-yyyy)		
PHN/ULI Date of Birth (dd-Mon-yyyy)		
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Discharging Unit Facility Name  Date of Requested for Transfer (dd-Mon-yyyy)		
Reason for Transfer Request		
Contact Name (person completing form) Phone Number		
Outbreak status of discharging unit?		
□ N/A □ Under investigation □ Open Outbreak		
El# (if required/available): Onset date (dd-Mon-yyyy)		
Etiological/Agent type:		
Attending/most responsible physician approves of pending discharge/transfer to a site with an open outbreak with transfer restrictions?		
□ No □ Yes □ N/A (receiving site not on outbreak)		
Informed consent obtained from patient/resident or guardian for discharge/transfer to site with an open outbreak with transfer restrictions?		
□ No □ Yes □ N/A (receiving site not on outbreak)		
Has client been identified as a close contact of a positive case? ☐ No ☐ Yes		
Symptoms of outbreak illness in patient/resident (ONLY complete if patient is coming from an outbreak unit/site)		
Last Swab collection date (if tested) (dd-Mon-yyyy) Result		
□ No (never symptomatic for outbreak illness)		
☐ Yes *If symptomatic at any point  → Onset date (dd-Mon-yyyy)		
Resolved date (dd-Mon-yyyy) Describe symptoms For <b>confirmed influenza outbreaks</b> only (at sending or receiving site): Immunization and/or antiviral		
prophylaxis		
Has the patient/resident received current season influenza vaccine?		
□ No → Provide vaccine for patient/resident prior to discharge.		
☐ Yes — Date of immunization (dd-Mon-yyyy)		
Has the patient/resident commenced antiviral prophylaxis?		
□ No → For influenza outbreak at receiving site, provide first dose of antiviral before transfer.		
☐ Yes → Start date (dd-Mon-yyyy)		
For <b>confirmed COVID-19 outbreaks</b> only (at sending or receiving site): Immunization		
Has the patient/resident received COVID-19 vaccine?		
□ No → Provide one dose of vaccine for patient/resident prior to discharge.		
☐ Partial series — Provide additional dose of vaccine ( <i>if eligible</i> ) for patient/resident prior to discharge.		
☐ Yes series complete — Date of immunization (dd-Mon-yyyy)		
Date of immunization (dd-Mon-yyyy)		
☐ Booster Dose — Date of immunization (dd-Mon-yyyy)		

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Related comorbidities (e.g., cardiovascular, renal disease, respiratory, immunocompromised, pregnancy):		
Cognition and compliance with recommended hygiene (Choose One)		
☐ Independent and compliant		
☐ Compliant but requires prompting (needs to be monitored)		
□ Non-compliant, mobile		
□ Non-compliant, mobile with assistance (walker, wheelchair, personal assistance)		
□ Non-mobile (bed-ridden)		
Receiving Unit/ Site/ Facility (To be completed by or in collaboration with the receiving unit/site/facility)		
Facility Name		
Floor/Unit	Room Number	
Contact Name (Person completing form)		
Phone number	Fax number	
Receiving site/unit in agreement with patient/resident transfer/admission:  □ No □ Yes		
Patient/Resident is being admitted to outbreak unit:		
□ No (outbreak information below not required)	☐ Yes (outbreak information required as listed below)	
Outbreak status of receiving unit?  □ N/A □ Under investigation EI# (if required/available):	☐ Open Outbreak Onset date (dd-Mon-yyyy)	
Etiological/Agent type:		
Accommodation Type:		
☐ Private room ☐ Private room with shared bathr	oom ☐ Shared (semi-private) room	
All outbreak control measures in place:		
□ No □ Yes		
Able to isolate/confine patient/resident to single room (if required):		
□ No □ Yes		
Able to carry out enhanced disinfection of room for remainder of outbreak (if required):		
□ No □ Yes		
Able to provide tray service to client in room (if required):  □ No □ Yes		
The following actions must be completed for confirmed influenza A or B outbreaks:		
<ul> <li>□ Arrangements made to continue antiviral prophylaxis, as required.</li> <li>□ Confirm that current season influenza vaccine has been/will be given prior to discharge (unless refused).</li> </ul>		
Transfer/Discharge Review (To complete as per zone processes)		
Transfer/Discharge  Transfer/Discharge		
☐ Approved ☐ NOT Approved		
	Data data and a	
Name of Approver/Title	Date (dd-Mon-yyyy)	
Outbreak Lead completing form (if applicable)		
Name	Date (dd-Mon-yyyy)	

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## **Risk Assessment Worksheet**

Notes/Instructions:

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