LASH
Los Angeles Surge Hospital

PRE-ADMISSION PACKET

CONTENTS

- ☐ L.A.S.H. Patient Acceptance Questionnaire
- ☐ L.A.S.H. Patient Transfer Checklist
- ☐ L.A.S.H. Discharge Planning and Transfer Back Agreement

INSTRUCTIONS

- ☐ Complete L.A.S.H. Patient Acceptance Questionnaire, L.A.S.H. Patient Transfer Checklist and submit forms with a hospital facesheet to Los Angeles County Department of Health Services, Medical Alert Center (MAC)/Transfer Center, Fax 562-906-4300.

- ☐ If pre-admission criteria are met, MAC will contact L.A.S.H. admitting office. After confirming bed availability, MAC will coordinate peer discussion between sending and L.A.S.H. physicians.

- ☐ Upon transfer acceptance, complete and return L.A.S.H. Discharge Planning and Transfer Back Agreement to MAC/Transfer Center, Fax 562-906-4300.

- ☐ MAC/Transfer Center will forward L.A.S.H. bed assignment, contact information for nursing report, and transportation instructions.

- ☐ Send the items listed on L.A.S.H. Patient Transfer Checklist with the patient at the time of transfer.

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
MEDICAL ALERT CENTER/TRANSFER CENTER
PHONE 866-940-4401
FAX 562-906-4300

Updated April 13, 2020

Los Angeles Surge Hospital

PATIENT ACCEPTANCE QUESTIONNAIRE

TO BE COMPLETED BY SENDING PHYSICIAN OR CASE MANAGER
ALL AREAS MUST BE COMPLETED

LOS ANGELES SURGE HOSPITAL is set up as a field hospital to accept transfer patients from area hospitals who are experiencing acute shortages of ICU or med/surg capacity due to COVID-19. LASH has ICU, step-down, and med-surg capabilities, with limited radiology, laboratory, and consultative services. Los Angeles County DHS Transfer Center to determine critical needs at referring facilities when prioritizing admissions.

DATE: _____ TIME: _____

PATIENT NAME: _____

TRANSFERRING HOSPITAL: _____

Answers with an asterisk (*) are a potential contraindication for admission

	YES	NO
Is the patient COVID-19 positive, confirmed by testing?	☐	☐*
Does the patient consent to transfer to L.A.S.H.?	☐	☐*
Does the patient have a stable residence and caregiver support at home upon discharge?	☐	☐*
Is the patient between 18 and 70 years old?	☐	☐*
Is the patient immunocompromised or S/P organ transplant ?	☐*	☐
Does the patient have a primary surgical diagnosis or need surgical intervention?	☐*	☐
Was the patient admitted for an acute cardiac event (e.g. STEMI) or CVA?	☐*	☐
Does the patient have recurrent seizures?	☐*	☐
Is the patient on CRRT?	☐*	☐
Was psychiatry/behavioral health the admitting diagnosis?	☐*	☐

Does the patient

Have an EF < 20%	☐*	☐
Require an FiO2 of > 80%	☐*	☐
Require a PEEP of >12	☐*	☐
Require more than 2 vasopressors	☐*	☐

REFERRING PHYSICIAN _____

CONTACT PHONE _____

CASE MANAGER _____

CONTACT PHONE _____

CONTACT FAX _____

SUBMIT BOTH PAGES OF THE COMPLETED L.A.S.H. PATIENT ACCEPTANCE QUESTIONNAIRE AND HOSPITAL FACESHEET FOR PRE-ADMISSION REVIEW TO:

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
MEDICAL ALERT CENTER
FAX 562-906-4300

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PATIENT TRANSFER CHECKLIST

TO BE COMPLETED BY SENDING PHYSICIAN OR CASE MANAGER
ALL AREAS MUST BE COMPLETED

Name:_____DOB:_____Gender _____

Address:_____ Phone: _____

_____

Emergency Contact (Name, Relationship): _____

Emergency Contact Phone #:_____

Insurance Provider:_____Insurance ID Number: _____

Secondary Insurance (if applicable):_____Insurance ID Number: _____

Current Treatment Provider: (Name)_____ (Phone) _____

Admitting Diagnosis:_____ Allergies: _____

Primary Language:_____Translation service needed? ☐ Yes ☐ No

Height (inches):_____ Weight: _____

Special Dietary Needs (if any): _____

SUBMIT THE COMPLETED L.A.S.H. PATIENT TRANSFER CHECKLIST AND HOSPITAL FACESHEET FOR PREADMISSION REVIEW TO:

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
MEDICAL ALERT CENTER
FAX 562-906-4300

ITEMS TO SEND WITH PATIENT TO L.A. SURGE HOSPITAL AT THE TIME OF TRANSFER:

- ☐ Copies of completed L.A.S.H. Patient Acceptance Questionnaire, L.A.S.H. Patient Transfer Checklist, and L.A.S.H. Discharge Planning and Transfer Back Agreement
- ☐ Hospital facesheet
- ☐ Reason for transfer (physician progress note or order)
- ☐ History and physical examination
- ☐ Daily progress notes
- ☐ Consultation reports
- ☐ Ancillary services notes (PT, OT, Respiratory Therapy, Case Management, etc.)
- ☐ Results of all relevant diagnostic tests, X-ray images (CD), and reports
- ☐ Medication administration record
- ☐ Advance directive
- ☐ Documentation of transfer consent

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DISCHARGE PLANNING AND TRANSFER BACK AGREEMENT

TO BE COMPLETED BY SENDING CASE MANAGER
ALL AREAS MUST BE COMPLETED

Date: _____ Sending Facility: _____

Medical Record #: _____

Facility Address: _____ Facility Phone #: _____

Patient Name: _____ Date of Birth: _____

Receiving Facility: **L.A. Surge Hospital**
Reason for Transfer: **Continuation of inpatient medical services**

Sending facility agrees that ***L.A. Surge Hospital*** is receiving the above-named patient for continuation of inpatient care services. Sending facility agrees to continue discharge planning, including coordination of post discharge follow up, durable medical equipment, and home health therapy. Sending facility understands and agrees that if the patient no longer requires clinical services for which he/she was referred and discharge to home is not practical, the patient will be transferred back to the sending facility for continued care.

The accepting physician at the sending facility is _____(name) and may be reached at_____ (phone) when patient is ready to be discharged. If the above accepting physician is unavailable, the hospital will assign another physician to assume care of this patient.

By signing below, I acknowledge that I am the individual at the sending facility who will be responsible for discharge planning and, if necessary, transfer back from the ***L.A. Surge Hospital.***

Sending Facility Discharge Planning and Transfer Back Contact:

Signature: _____

Name: _____

Title: _____

Phone Number: _____

Date and Time: _____

Next of Kin/Caregiver and Discharge Address:

Name: _____

Discharge Address: _____

City, State, Zip Code: _____

Phone Number: _____

Sending Facility Chief Executive Office, Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, Director of Case Management, or other senior member of the executive staff:

Signature: _____

Name: _____

Title: _____

Phone Number: _____

Date and Time: _____

SUBMIT BOTH PAGES OF THE COMPLETED L.A.S.H. DISCHARGE PLANNING AND TRANSFER BACK AGREEMENT TO:

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
MEDICAL ALERT CENTER
FAX 562-906-4300