SURGE HOSPITAL PRE-ADMISSION PACKET

CONTENTS

- ☐ Surge Hospital Patient Acceptance Questionnaire
- ☐ Surge Hospital Patient Transfer Checklist

INSTRUCTIONS

- ☐ Complete and submit the following forms and reports with a hospital face sheet to Los Angeles County Department of Health Services, Medical Alert Center (MAC)/Transfer Center, Fax 562-906-4300.
    - Surge Hospital Patient Acceptance Questionnaire
    - Surge Hospital Patient Transfer Checklist
    - History and physical examination (H&P)
    - Physician Orders
    - Medication administration record (MAR)
    - Recent progress notes (up to 3 days) (as applicable)
    - Vent / oxygenation settings (if applicable)
    - COVID-19 Treatments to Date
    - Case management report/notes (if applicable)
    - Social services report/notes (if applicable)

- ☐ If pre-admission criteria are met, the Surge Hospital will coordinate peer discussion between sending and receiving physicians.
- ☐ The Surge Hospital will notify the sending hospital of the accepting bed assignment, contact information for nursing report, and transportation instructions.
- ☐ Send a copy of the chart and pertinent imaging studies 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

SURGE HOSPITAL PATIENT ACCEPTANCE QUESTIONNAIRE

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

Surge Hospitals are licensed acute care facilities accepting transfer patients from area hospitals who are experiencing acute shortages of ICU or med/surg capacity due to COVID-19. Both COVID positive and COVID negative patients are acceptable for transfer. These facilities have ICU, telemetry and med-surg capabilities. Los Angeles County Medical Alert Center to determine critical needs at referring facilities when prioritizing transfers.

DATE *(month/day/year)*: ____/_____/______ TIME: _______:______AM / PM *(circle)*

PATIENT NAME: ____

TRANSFERRING HOSPITAL: ____

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

	YES	NO
Does the patient consent to transfer– Attach a copy of the signed consent	☐	☐*
Does the attending physician of record agree to transfer?	☐	☐*
Does the patient have an available family contact/representative?	☐	☐
Is the patient's family aware and in agreement with the transfer?	☐	☐
Is the patient COVID-19 positive (confirmed by testing)?	☐	☐
Does the patient require hemodialysis (yes is an exclusion to transfer; ICU patients on continuous renal replacement therapy (CRRT) can be transferred)?	☐*	☐
Does the patient have behavioral or mental status conditions that require restraints or a sitter or are they on conservatorship (transfer dependent on behavior health bed availability)?	☐*	☐
Is the patient a trauma patient?	☐*	☐
Does the patient have head trauma or intracranial hemorrhage (e.g. hemorrhagic stroke)	☐*	☐
Does the patient require thoracic surgery?	☐*	☐
Does the patient have cardiac catheterization lab needs?	☐*	☐

	YES	NO
Is the patient pregnant?	☐*	☐

**** Please ensure appropriate patient consent has been obtained and attending physician agrees with transfer prior to initiating a transfer request. Ability to accept transfer will be determined by receiving physician. Please be prepared to provide level of care needed (i.e. ICU, telemetry, med/surg).***

REFERRING PHYSICIAN NAME: ____

REFERRING PHYSICIAN PHONE: (__________)_____________-__________________

CASE MANAGER NAME: ____

CASE MANAGER PHONE: (__________)_____________-________________________

CASE MANAGER FAX: (____________)_____________-________________________

SUBMIT BOTH PAGES OF THE COMPLETED PATIENT ACCEPTANCE QUESTIONNAIRE AND HOSPITAL FACESHEET FOR PRE-ADMISSION REVIEW TO:

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

Last updated: February 2, 2021

SURGE HOSPITAL PATIENT TRANSFER CHECKLIST

TO BE COMPLETED BY SENDING PHYSICIAN OR CASE MANAGER

ALL AREAS MUST BE COMPLETED

Name: ____________________ DOB: ____/____/____ Gender: ________

Address: ____________________ Phone: (____) ____-________

Sending Hospital: ____

Emergency Contact (Name, Relationship): ____________________

Emergency Contact Phone: (____) ____-________

Insurance Provider: ____________________ Insurance ID Number: ____________________

Secondary Insurance (*if applicable*): ____________________ Insurance ID Number: ____________________

Attending Physician: (*Name*)____________________ *Phone*: (____) ____-________

Patient Location:____________ Nurses Station Phone:____________Bed Type Requested:________

Case Manager: ____________________ Phone: (____) ____-________

Height (inches): ____________________ Weight: ____________________

Admitting Diagnosis: ____________________ Allergies: ____________________

Vital Signs: B/P:________Pulse:________RR:________Temp:________Covid/Status/Date:____________

Oxygen Rate Delivery Device: ____________________ Oxygen L/Min: ____________________

Ventilation Setting: ____

Primary Language: ____________________ Translation service needed? ☐ Yes ☐ No

Patient (or next of kin) consents to transfer: ☐ **Yes** ☐ **No**

Attending Physician of Record agrees to transfer patient: ☐ **Yes** ☐ **No**

SUBMIT THE COMPLETED SURGE HOSPITAL PATIENT TRANSFER CHECKLIST AND HOSPITAL FACESHEET FOR PREADMISSION REVIEW TO:

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

MEDICAL ALERT CENTER/TRANSFER CENTER

PHONE 866-940-4401

FAX 562-906-4300

SURGE HOSPITAL PATIENT TRANSPORTATION

1. The sending hospital is responsible to arrange the ambulance transportation once the transfer request is approved and the transfer accepted.

2. The ambulance provider will bill the patient for the transport. If the patient does not have insurance and does not have the ability to pay, then the ambulance provider can request payment for the transport from the Emergency Medical Services Authority dependent on the ambulance provider having a signed agreement with EMSA.

3. If the sending hospital is having difficulty finding an available ambulance provider to do the transport, they can contact the Department of Health Services Central Dispatch Office (CDO) at 866-941-4401 and request CDO's assistance in finding an available ambulance provider to do the transport.

4. If CDO schedules the transport they will ensure the ambulance provider is informed that they need to bill the patient for this transport.

High Flow Oxygen Therapy Ambulance Providers:

AMR (877) 808-2100

AmWest (818) 859-7999

CAL-MED (877) 686-5522

Liberty (877) 542-7773

Critical Care Transportation Providers:

Ambulnz (877) 311-5555

AmbuServe (310) 644-0500

AMR (877) 808-2100

American Professional Ambulance (888) 703-3500

AmWest (818) 859-7999

CAL-MED (877) 686-5522

Firstmed (800) 608-0311

Liberty (877) 542-7773

MedCoast (866) 926-9990

Medic-1 (800) 814-1160

Premier (888) 353-9556

PRN (866) 776-4262

Royalty (877) 703-6111

Symbiosis (866) 776-4262

Viewpoint (888) 202-6500

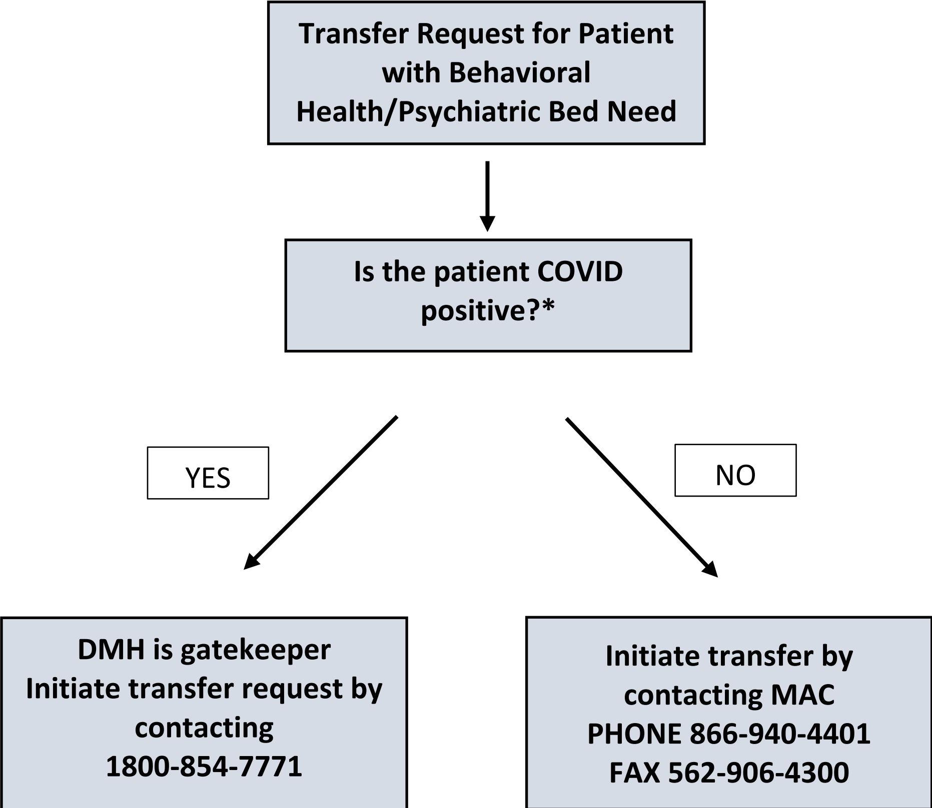
Dialysis Transportation:

Medtrans (323) 780-9500

SMS (310) 329-7062

Central Dispatch Office: (866) 941-4401 – if you are unable to arrange transportation.

Pacifica of the Valley Hospital Behavioral Medical Transfer Guidance Flowsheet



*patients that have tested positive for COVID may have a positive test for months but are no longer contagious and may be medically cleared for psychiatric placement. If COVID+ patients have documented medical clearance of their COVID status and have no other medical issues, they can be processed by the MAC.