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| **COVID 19 TEMPORARY ACCOMMODATION REQUEST**  **RISK ASSESSMENT**  **Patient with confirmed COVID-19 or**  **their Close Contacts** | | | | | | | | | | | | | NSW Health Western Sydney LHD - 2 col RGB | | | | | | | |
| **Patient Details** | | | | | | | | | | | | | | | | | | | | |
| **Date of request** | | | | **Patient Name** | | | | | | **MRN / AUID** | | | | | | | **Contact Number** | | | |
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| **Usual Residential Address** | | | | |  | | | | | | | **Email Address** | | | | |  | | | |
| **Requestor Details**  **Form to be completed by: Nursing Unit Manager / Team Leader for patients OR case interviewer from the Public Health Unit for close contacts** | | | | | | | | | | | | | | | | | | | | |
| **Requestor’s Name** | | | | |  | | | | | | | **Role at WSLHD** | | | | |  | | | |
| **Contact Number** | | | | |  | | | | | | | **Contact Email** | | | | |  | | | |
| **Patient’s Referral Source** | | | | | - Community | | | - Discharging Inpatient | | | | - Public Health Unit | | | | | | - Other: | | |
| **Patient Eligibility**  **The requestor must confirm that the patient is eligible for temporary accommodation** | | | | | | | | | | | | | | | | | | | | |
| **The person requiring temporary accommodation must be:** | | | | | | | | | | | | | | | | | | | | **Tick to confirm (✓)** |
| A patient of WSLHD (e.g. community, discharging in-patient) OR  has been assessed by WSLHD’s Public Health Unit | | | | | | | | | | | | | | | | | | | |  |
| COVID positive required to self-isolate OR  a close contact of a COVID positive person and required to self-isolate | | | | | | | | | | | | | | | | | | | |  |
| Unable to safely self-isolate at their usual residence | | | | | | | | | | | | | | | | | | | |  |
| Able to live independently and self-caring | | | | | | | | | | | | | | | | | | | |  |
| **Risk Assessment**  **To be completed by the requestor** | | | | | | | | | | | | | | | | | | | | |
| **The Risk Assessment process involves:**  Identifying factors for patients who may need temporary accommodation due to COVID-19 Response.  Refer to the Fact Sheet for more information, including explanations of the “*Reasons for Temporary Accommodation Request*” below. | | | | | | | | | | | | | | | | | | | | |
| **Risk Criteria Number:** | **Reason for Temporary**  **Accommodation Request:** | | | | | | | | | **Request Details:** | | | | | | | | | | **Indicate reason (** **✓)** |
| **1** | Patients without a permanent place of residence | | | | | | | | |  | | | | | | | | | |  |
| **2** | Patients who are COVID positive or a close contact of a COVID positive person, and are unable to self-isolate safely | | | | | | | | |  | | | | | | | | | |  |
| **3** | The presence of a vulnerable person in the patient’s usual place of residence | | | | | | | | |  | | | | | | | | | |  |
| **4** | Public health risk to self or others | | | | | | | | |  | | | | | | | | | |  |
| **5** | Other reasons | | | | | | | | |  | | | | | | | | | |  |
| **Accommodation Requirements**  **To be completed by the requestor** | | | | | | | | | | | | | | | | | | | | |
| **Does the patient require meal provision during their accommodation stay?**  Note: this is for COVID positive people or people who do not have identified support people in their community to deliver food supplies.  - Yes  - No  **If Yes, identify any dietary requirements:** | | | | | | | | | | | **Does the patient have additional family members who will accompany them to the temporary accommodation?**  - Yes  - No  **If Yes, identify how many family members and their relationship to the patient:**  (e.g. patient will be accompanied by her two children) | | | | | | | | | |
| **Are car parking facilities required?**  - Yes  - No | | | | | | | | | | | **Please identify any additional considerations for this patient while they are in temporary accommodation:**  (e.g. patient has a service animal) | | | | | | | | | |
| **Patient Care whilst in Temporary Accommodation**  **To be completed by the requestor** | | | | | | | | | | | | | | | | | | | | |
| **Is a referral to a WSLHD Service required to support this person during and/or after their accommodation stay?**  The requestor is responsible for actioning any referrals via normal referral processes. | | | | | | | | | | | | | | | | | | | | |
| - HITH | | | | | | | - Social Work | | | | | | | | | - No referral needed | | | | |
| **Has a care plan been developed for this patient during their stay in temporary accommodation?**  The requestor is responsible for ensuring an appropriate care plan is in place where necessary . | | | | | | | | | | | | | | | | | | | | |
| - Yes | | | | | | - No | | | | | | | | - No care plan needed – patient is a close contact being monitored via MOH survey | | | | | | |
| **Does the patient have an existing relationship with community support services?**  (e.g. home care, Meals on Wheels etc.)  - Yes  - No  If yes, please include details of services to be continued in the patient’s temporary accommodation care plan. | | | | | | | | | | | | | | | | | | | | |
| **Duration of Temporary Accommodation**  ***To be completed by the Tier 3 / General Manager*** | | | | | | | | | | | | | | | | | | | | |
| **Start Date** | |  | | | | | | | | | **Duration needed**  **(days)** | | | |  | | | | | |
| **Accommodation Type**  ***To be completed by Tier 3 / General Manager*** | | | | | | | | | | | | | | | | | | | | |
| The type of accommodation offered to patients is managed through FCM Travel.  Accommodation at Casuarina Lodge should only be offered for emergency after-hours accommodation requests. | | | | | | | | | | | | | | | | | | | | |
| **Order** | **Accommodation Type** | | | | | | | | | | | | | | | | | | | |
| **1** | FCM Booking for hotel accommodation | | | | | | | | | | | | | | | | | |  | |
| **2** | Casuarina Lodge (located at Westmead Hospital)  For emergency after-hours accommodation only   * GM’s Office has contacted and confirmed the available unit at Casuarina Lodge * Unit Number: \_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |  | |
| **Request Review**  ***To be completed by the Tier 3 / General Manager.***  **The review must occur at the date specified to reassess the patient / community member’s accommodation needs.** | | | | | | | | | | | | | | | | | | | | |
| **Request review date** | | |  | | | | | | **Comments** | | |  | | | | | | | | |

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| **Approvals** | | |
| **In Hours (0730 – 1600)** | **Weekends and After Hours (1600 – 0730)** | |
| **Tier 3 / General Manager**  Approved  Not Approved  **Name:**  **Designation:**  **Facility:**  **Date:** | **Inpatient requests** | **Community requests** |
| **After Hours Nurse Manager**  - Approved  - Not Approved  **Name:**  **Designation:**  **Facility:**  **Date:** | **ICH Executive On-Call**  - Approved  - Not Approved  **Name:**  **Designation:**  **Facility:**  **Date:** |
| *Once complete, send to the WSLHD Accommodation Procurement email:* [*WSLHD-COVIDAccommodation@health.nsw.gov.au*](mailto:WSLHD-COVIDAccommodation@health.nsw.gov.au) | *Once complete, send to the appropriate Tier 3 / General Manager – refer to Fact Sheet for contacts list.* | |
|  | **Tier 3 / General Manager**  Approved  Not Approved  **Name:**  **Designation:**  **Facility:**  **Date:** | |
| *Once complete, send to the WSLHD Accommodation Procurement email:* [*WSLHD-COVIDAccommodation@health.nsw.gov.au*](mailto:WSLHD-COVIDAccommodation@health.nsw.gov.au) | |