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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) ORhas 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 [ ]  - NoIf 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* | *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* |