RUHS – Public Health
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Please Fax to (951)358-5446 or email bcole@ruhealth.org

CONFIDENTIAL
RUHS PUBLIC HEALTH
DISEASE CONTROL
ASSESSMENT FOR TEMPORARY HOUSING

General Assessment

Patient Name:_____DOB: _____Race/Ethnicity

Address:_____ Patient Cell phone: _____

Facility:_____ Contact Person: _____

If completed by patient, write "SELF"

Facility Phone:_____ Fax:_____

Date Hospitalized: _____ Date Tested: _____ Results Date: _____

1. What is the COVID-19 test result? □ Positive □ Negative □ Indeterminate □ Pending
   IF POSITIVE, COPY OF POSITIVE LAB REPORT MUST BE ATTACHED
   (PH Discharge approval is not required for individual with negative tests results)
2. Is the patient symptomatic? □ No □ Yes Onset Date: _____
3. Has the patient been afebrile for 24 hours without antipyretics, shown substantial or complete improvement in symptoms and is at least 10 days from date of a positive test — □ Yes □ No
4. Is patient experiencing any of the following signs or symptoms? — □ Fever □ Chest Pain □ Other □ Cough □ Shortness of breath □ None
5. Is patient clinically stable? — □ Yes □ No
6. Are there High-Risk people in the household? — □ Yes □ No
7. If yes check all that apply:
   - □ Young Infant □ Elderly
   - □ Immunocompromised □ Other

7. Returning to same address? — □ Yes □ Not returning to same address

_____
(Address location)

8. Can patient be safely isolated at home? □ Yes □ No
9. Patient agrees to home isolation □ Yes □ No (*cannot be discharged*)

Note: Temporary housing is not available for patients who test negative for COVID-19

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Assessment for Temporary Housing

10. Is patient homeless? □ Yes □ No

11. Can other housing arrangements be made? □ Yes □ No

12. Does patient require oxygen? □ Yes □ No

13. Is the patient on medication? □ Yes □ No If yes, specify _____

14. Does patient have substance abuse problem? □ Yes □ No Specify_____

15. Can patient perform their own ADL? □ Yes □ No

16. Clean their own room? □ Yes □ No

17. Does patient agree to follow the rules for temporary housing which prohibits smoking, drug use, alcohol use, unauthorized visitors, and to vacate the room upon request from the Public Health Department □ Yes □ No

18. Is meal assistance needed? □ Yes □ No

19. Does the patient have access to transportation □ Yes □ No

    If yes, please list method of transportation: _____

    If no, will hospital/facility provide transportation □ Yes □ No

20. Respiratory precautions are required for transport to housing unit.
    What company will be used? _____

FOR HEALTH DEPARTMENT USE ONLY

Temporary Housing Approved: □ Yes Location _____

□ No_____
Reason

Date meal assistance requested _____

Agency Referral_____ Date Referred_____

Length of Projected Stay_____ Date and Time Vacated_____

Reason for Vacating

- □ Isolation Completed
- □ Voluntarily Vacated
- □ Failure to comply with rules, patient instructed to vacate temporary housing.

Date _____

_____
Barbara Cole RN, MSN
Director Disease Control

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