

Use this form to determine if the patient can return to a facility experiencing an outbreak.

Instructions: Process should be completed within 24 hours of initiation.

Step 1: Hospital to complete Section A and fax/email it to the Facility where the patient is to return.

Step 2: Facility to complete Sections B and indicate in Section C if agreeable to repatriation, then fax/email to the hospital where the resident is admitted.

Step 3: If repatriation is mutually agreed upon, LTCH/RH staff calls hospital to discuss date and time for repatriation and completes the appropriate fields in Section C. Health Unit does not need to be notified.

Step 4 (optional): Facility or hospital staff can request a consultation from the Health Unit by checking the appropriate box in Section C and faxing/emailing form to the Health Unit. A request can be made during regular business hours (Monday - Friday 8:30am - 4:30pm) at 1-866-888-4577 x 1232 for HKPR or 705-743-1000 x 131 for PPH. The Health Unit outbreak investigator will review information provided in Sections A and B, and the Health Unit outbreak record and provide a recommendation to the Facility and Hospital. This recommendation can then be considered by Hospital and Facility staff in the repatriation decision making process. Revisions to the repatriation plan may also be suggested by the Health Unit. If the Facility and Hospital revise the decision to repatriate, return to Step 3.

SECTION A – Hospital

Name and Title:	Hospital:
Unit/Department:	Phone Number:
Date (YY/MM/DD):	Fax Number:
Patient's ID Number:	
Patient's Initials :	Date of Birth (YY/MM/DD):
Date of planned discharge from hospital to facility (YY/MM/DD)?	
Will this patient be a new admission into the facility? ☐ Yes ☐ No	
Does the patient's attending physician at the hospital agree to the admission/return based on a review of the current health status and the outbreak situation at the receiving facility? ☐ Yes ☐ No	
What special care/level of care will this patient require upon return to the facility that was not required prior to hospital admission?	

Repatriation plan – The following measures will be done prior to return to facility to protect the resident from illness during this outbreak (check those that apply):

- ☐ Hospital staff have discussed the outbreak situation, and risks and benefits of repatriation/admission to facility during an outbreak situation with the resident/resident's substitute decision maker, and obtained informed consent
- ☐ If the outbreak organism has been identified as influenza A, antivirals have been provided to the patient.
- ☐ Proposed date and time for repatriation to LTCH/RH:

SECTION B – Facility

Name and Title:	Hospital:
Unit/Department:	Phone Number:
Date (YY/MM/DD):	Fax Number:
What is/are the causative agent(s) of the outbreak?	
What is the attack rate to date?	

Residents:	Staff:
Are cases located throughout the facility or localized?	
Is transmission still occurring?	☐ Yes ☐ No
If yes, onset date of the last case? (YY/MM/DD)	
What is the approximate duration of illness?	
Percentage of cases, as of this date, hospitalized related to outbreak illness?	
Percentage of outbreak-related deaths, as of this date?	
Are cases experiencing severe symptoms (e.g. pneumonia)?	☐ Yes ☐ No
If yes, percentage of cases, to date, with severe symptoms?	
Would this resident be returned/admitted to an area where there is/are case(s)?	☐ Yes ☐ No
If facility is experiencing an influenza outbreak, has the patient been immunized?	☐ Yes ☐ No
What are the concerns about admitting/repatriating this patient to your facility (e.g. staffing capacity, meeting patient's care needs, protecting patient from transmission of infection, patient's susceptibility to complications from infection, etc.)?	
Repatriation plan – Can the following measures be done if the resident returns to the facility to protect the resident from illness during this outbreak (check those that apply): ☐ tray service provided to resident ☐ resident kept in isolation ☐ resident will be returned to a private room/unaffected area of facility	
SECTION C- Repatriation Plan	
☐ Facility agrees to repatriate based on the above information ☐ Facility does not agree to repatriation based on the above information ☐ Facility requests Health Unit consultation	☐ Hospital requests Health Unit consultation ☐ If facility agrees to repatriation, date and time for repatriation that hospital and LTCH/RH have agreed upon: Date: Time:
Signature:	Signature:
Title:	Title:
SECTION D (if required) – Health Unit: Lakelands Public Health	
Name and title:	Phone Number:
Date (YY/MM/DD):	Fax Number:
Public Health Recommends:	
☐ Return/admit into the facility (<u>provided conditions listed under comments are met</u>) ☐ DO NOT return/admit into the long-term care home at this time	
Comments:	
Signature:	
Have previous requests for this patient been submitted? ☐ Yes ☐ No If yes, date:	

Hospital ID number: