**Individual Name:**  **ID #:**  **Date/Time:** 

**Contact Method:**  **Caregiver Interviewed (Name):** 

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Individual/Caregiver reported any of the following: Fever, Cough or other symptoms |[ ] [ ]
| If **Yes**, specify: Click or tap here to enter text.If **YES**, when did they start? ­­­­­Click or tap here to enter text. |[ ] [ ]
| **If YES, has their primary care provider been contacted?** **Instructions:** Click or tap here to enter text. |[ ] [ ]
| If **NO**, indicate follow-up including notification to primary care provider.Click or tap here to enter text. |[ ] [ ]
| Individual has adequate medication supply/medical supplies (e.g. oxygen, wound care products, tube feeding formula). |[ ] [ ]
| Individual/caregiver understands when to seek emergency medical assistance.  |[ ] [ ]
| Individual/caregiver is utilizing telehealth for essential physician appointments. |[ ] [ ]
| Individual Support Plan is current and addresses individual health/support needs. |[ ] [ ]
| Individual’s caregiver is attending to the individual per the current ISP and per new COVID-19 standards agreed upon by the individual/team. |[ ] [ ]
| Individual/caregiver has the DHSS COVID-19 hotline number if needed: 877-435-8411. |[ ] [ ]
| Individual has adequate over the counter supplies to treat fever and other symptoms?  |[ ] [ ]
| If **NO**, what is needed?Identify plan to address: Click or tap here to enter text. |[ ] [ ]
| Individual/caregiver has proper and adequate Personal Protective Equipment (PPE). |[ ] [ ]
| If **NO**, what is needed?Identify plan to address: Click or tap here to enter text. |[ ] [ ]
| Individual has meals to eat/groceries/nutritional supplements on hand for several days. |[ ] [ ]
| If **NO**, what is needed?Identify plan to address: Click or tap here to enter text. |[ ] [ ]
| Agency has operational emergency plan in place to ensure individual’s needs are met during the pandemic.  |[ ] [ ]
| Individual has access to phone and other electronic devises to keep in contact with family and friends.  |[ ] [ ]

If any of the above statements are marked **NO**, please explain in the space below and if necessary, who you contacted for follow-up (agency supervisor, physician, other).

Click or tap here to enter text.

**COMMENTS** (Please include any training/educational resources provided to individual and/or caregiver(s) i.e. Infection control measures, environmental hygiene, good handwashing, proper utilization of PPE, agency policy for communication when potential COVID-19 symptoms are identified):

Click or tap here to enter text.

\*Additional documentation can be recorded in the Monthly RN Oversight Summary.

Nurse Signature: Click or tap here to enter text.