COVID-19 Quarantine Intake Assessment Tool

STATE OF NEW HAMPSHIRE

COVID-19 Quarantine Intake Assessment Tool

Referral

Referring Org/ Location: ____

Referring Party: _______________________________ Telephone: (___) ____ - ________

Client Information:

Client Name:____

Client's DOB: ____ / ____ / ________ Age: ______ Telephone: (___) _____ - ____________

Current Location: ____

____

Client's Housing Status & Location: ____

____

Medical Needs:

COVID-19 Tested: **N** / **Y** Date: ______ / ______ / ____________ **+** / **-**

Testing Location: ____

Referral for: Self-Monitoring / Quarantine / Isolation Duration: ________________

Symptoms: ____

____

Brief Medical, Behavioral Health & Social History: ____

____

____

____

Functional Needs: ____

Dietary Concerns: ____

Primary Care Provider:	
Other Care Team Members:	

Coordination Special Needs/Concerns

Barrier to Success?

	Medications		
	Functional Access		
	Nutrition		
	Medical Care		
	Behavioral Health		
	Social Services		

Recommended Disposition

Location

	Inpatient/ACS	
	Community Site	
	New Shelter	
	Previous Shelter	
	Other	

Priority Support Plans

	Transportation Plan
	Housing Plan
	Medical Plan
	Behavioral Health/Substance Use Disorder Plan

Internal Use Only:

Date Assessment Was Completed: ______ / ______ / ____________

Assessment Completed By: ____

Phone: ____

Notes:

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