Isolation & Quarantine Referral Information for Health Care Providers
May 26, 2020

Snohomish County health care providers:

If you identify someone who:
  • has tested positive for COVID-19 or has test results pending
  • does not need hospitalization
  • cannot isolate themselves in a safe/secure environment
you can refer the person to Snohomish County’s Isolation/Quarantine Facility at the Angel of the Winds Arena in Everett.

The process is very easy (see attached Referral Flyer), but must start with a call to the Facility (425-238-3439). Facility staff will ask the questions on the Q&I Site Referral Form (attached), but you do not need to send the form.

Thank you for helping us to protect the entire community.

Attached:
  • Isolation and Quarantine Referral Flyer
  • Isolation and Quarantine Referral Form
1. Call the I/Q Facility (425-238-3439) to provide information about potential referral including:

- Client name & date of birth,
- If tested (when, results, lab used),
- Symptoms with onset dates,
- Other medical problems (esp. mental health or substance abuse),
- Current medications,
- Allergies, and
- Withdrawal risk (substance & time of last use).

2. Site Coordinators will consult with the Snohomish Health Officer to confirm approval for admission.

3. If the patient meets criteria and health officer approval or order is issued, the IQF staff will call you to initiate the transfer. PRIOR TO TRANSFER, please CONFIRM testing has been done and they have a 14-day supply of their medications and include first dose of suboxone if indicated.


If your patient has symptoms of or tested positive for COVID-19 and does not need to be hospitalized, you may refer them to the IQF.
Quarantine and Isolation Site Referral Form

Healthcare professional calls the Quarantine/Isolation Site Manager at 425-238-3439 to provide the following information:

Today’s date___________________
Client Name ___________________________ Date of Birth___________________
Has the client been tested for COVID-19?  Yes  No  If yes, test date _________________
If yes, are there results on hand? (fax copy to 425-322-2762)  Yes  No
If pending, to what lab was the test sent? _______________________________________

Current Symptoms:

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Date of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever – temperature:</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Cough</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Chills</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Headache</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Muscle Aches</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Loss of smell or taste</td>
<td>Yes  No</td>
</tr>
<tr>
<td>GI distress (including diarrhea)</td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

Other medical problems:
______________________________________________________________________________
______________________________________________________________________________

Known medications (attach med list if not enough room):
______________________________________________________________________________
______________________________________________________________________________

Known allergies: __________________________________________________________________

Is the individual at risk of withdrawal from opiates, benzodiazepines, or alcohol?  Yes  No
If so, what substance(s) and time of last use:
______________________________________________________________________________

Name of person filling out form: ________________________________________________

Signature: ____________________________________________________________________

Organization and contact information: ____________________________________________