OMB Approved
OMB No. 0920-1290
Exp. Date 09/30/2020
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COVID–19 Module
Dialysis Outpatient Facility

Facility Operational Information
Facility ID (OrgID)_____
CMS Certification Number (CCN)_____
Facility Name_____

Date for which responses are reported ___/____/_____

In-Center Patient Census_____
Home Patient Census _____

Total Certified Stations_____

Isolation Stations Included in Total Certified Stations_____

Is your facility a designated COVID unit?_____

If no, does your facility have designated COVID shifts?_____

How many patients on the current in-center census reside in long-term care facilities (LTCFs)?

How many patients on the current home census reside in LTCFs?

COVID–19 Positive (+) Patients and Staff

Number of newly-confirmed patients since last reporting_____
Number of newly-confirmed patients since last reporting that reside in LTCFs _____
Number of newly-confirmed patients since last reporting that are home patients _____
Number of newly-confirmed staff since last reporting_____
Number of confirmed patients currently admitted to hospital/receiving treatment in hospital _____
Number of confirmed patients currently self-monitoring and continuing in-center therapy _____
Number of confirmed patients currently self-monitoring and continuing home therapy _____

Patients Under Investigation (PUI) *Only Identify persons being tested for COVID-19*

Number of new PUIs since last reporting_____

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Number of new PUIs that reside in LTCFs since last reporting _____
Number of new Staff under investigation since last reporting_____

Tested Negative (-) for COVID-19

Number of Patients newly tested negative since last reporting _____
Number of Staff newly tested negative since last reporting_____

COVID–19 Positives (+) that have recovered

Number of Patients recovered since last reporting_____
Number of new Staff recovered since last reporting _____

COVID– 19 Positive (+) Deaths

Number of new Patient deaths with COIVD-19 since last reporting_____
Number of new Staff deaths with COVID-19 since last reporting_____

Staff and/or Personnel Impact	
Will your facility have a shortage of staff and/or personnel within the next week?	
Staffing Shortage?	**Staff and Personnel Groups**
☐ Yes ☐ No	**Nursing Staff**: registered nurse, licensed practical nurse, vocational nurse
☐ Yes ☐ No	**Clinical Staff**: physician, physician assistant, advanced practice nurse
☐ Yes ☐ No	**Tech**: dialysis technician
☐ Yes ☐ No	**Other staff or facility personnel**, regardless of clinical responsibility or resident contact not included in the categories above (for example, environmental services, biomed)

Supplies & Personal Protective Equipment (PPE)		
Supply Item	**Do you currently have any supply?**	**Do you have enough for one week?**
N95 filtering facepiece respirators	☐ Yes ☐ No	☐ Yes ☐ No
Facemasks	☐ Yes ☐ No	☐ Yes ☐ No
Eye protection, including face	☐ Yes	☐ Yes

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shields or goggles	☐ No	☐ No
Isolation Gowns	☐ Yes ☐ No	☐ Yes ☐ No
Gloves	☐ Yes ☐ No	☐ Yes ☐ No
Alcohol-based hand sanitizer	☐ Yes ☐ No	☐ Yes ☐ No

Laboratory Testing	
☐ Yes ☐ No	Does your facility have onsite testing for COVID-19?
☐ Viral (PCR) ☐ Antigen ☐ Antibody	If yes, what types of tests are being performed?
☐ NP swab ☐ Anterior Nares ☐ Mid Turbinate ☐ OP swab ☐ Saliva	If yes to viral (PCR) tests, what types are being performed?