

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 _____

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

CDC estimates the average public reporting burden for this collection of information as 20 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1290)
CDC.

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 COVID-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 |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Nursing Staff: registered nurse, licensed practical nurse, vocational nurse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Clinical Staff: physician, physician assistant, advanced practice nurse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Tech: dialysis technician |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Facemasks | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye protection, including face | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |

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| | | |
|------------------------------|---|---|
| shields or goggles | <input type="checkbox"/> No | <input type="checkbox"/> No |
| Isolation Gowns | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gloves | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol-based hand sanitizer | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

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