STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
DIVISION OF MEDICAL AND FORENSIC SERVICES

Helen E. Hanks
Commissioner

Paula L. Mattis
Director, Medical and Forensic Services

To: All Wardens and Directors
From: Paula Mattis, Director, Medical and Forensic Services
Date: March 16, 2020
Re: Access to NHDOC Facilities to Aid in Prevention of COVID-19
Effective March 17, 2020:

Each staff member is required to complete this form prior to entering a DOC facility.

1. Have you had contact or close association with any person that has tested positive for COVID-19 or is presumed to be positive?

☐ YES ☐ NO

2. Have you been contacted by Public Health to initiate self-quarantine?

☐ YES ☐ NO

If the employee answers "yes" to question 1 or 2 they will not be allowed access to the facility. They should contact HR and their supervisor.

3. Do you have

A cough of unknown origin? ☐ YES ☐ NO

Shortness of breath? ☐ YES ☐ NO

4. Are you currently using, or have used in the last two weeks, cough suppressants, decongestant, Tylenol or other symptom-reducing medications?

☐ YES ☐ NO

If the employee answers "yes" to question 3 or 4 they shall be referred to the designated medical screener.

_____ _____ _____
Employee Name Employee Signature Date

Temperature:

If the person's temperature is at or above 100.4 F, they should be told to go home, contact HR, and contact their supervisor.

_____ _____ _____
Person taking temperature Signature Date

Please forward this completed form to NHDOC Human Resources.

Designated Medical Screener Numbers

NHSP-M	271-1853
NHCFW	271-0874
SPU/RTU	271-1839
NCF	752-0345

Progress Note

(Progress note not required unless the employee has to be assessed by a Medical Screener.)

New Hampshire

Department of Corrections

Division of Medical & Forensic Services

Corona Virus-COVID 19 Screening Form

Patient Name:	
ID Number:	
Date of Birth:	

Location:

☐ **NHSPM** ☐ **NHSPW** ☐ **NCF** ☐ **SPU/RTU**

Patients presenting with IFL including cough, fever, and shortness of breath should be isolated prior to assessment.

Temperature: BP: Pulse 02: Respirations: Heart rate:

Does the patient have a fever?

Is the patient coughing?
(If yes, document patient's report of frequency, how long they have had the cough, nature of cough as well as your clinical observation.)

Is the patient experiencing shortness of breath?
(Document patient's description, clinical observations, and breath sounds.)

Is the person immunocompromised?
(Document chronic conditions such as diabetes, lung disease, heart disease and acute conditions such as flu.)

Additional comments:

If the patient has a fever, cough, and shortness of breath, administer the Rapid Flu Test. If positive, treat accordingly.

If the Rapid Flu Test is negative, place the patient in isolation in treatment facility. Contact a medical provider. Give the medical provider the above information. Follow treatment plan as prescribed by provider.

- All staff should initiate STANDARD, CONTACT, and DROPLET precautions (Double glove, mask with face shield, gown, booties)
- Notify the following people:
    1. Chief Medical Officer
    2. Director of Nursing
    3. Captain's Office
    4. Director of Medical and Forensic Services

Staff Signature: _____Date: ___/___/____Time: ___:___

Upon completion, this form should be scanned into the electronic health record