Alabama Department of Public Health: Tele-ICAR Information Form
Send to: Melanie Chervony, MPH
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Contact info
Facility POC
Name: ________________________________________________________________
Facility POC Title: ______________________________________________________
POC Phone: __________________________________________________________
POC E-mail: __________________________________________________________
Address: _____________________________________________________________
Facility Name: _________________________________________________________
Facility County: _______________________________________________________

- Total number of residents in the facility: _____________
- Total number of staff in the facility: _____________
- Total number of units: _____________
  o Specialty Units (check all that apply): ☐ Vent/trach ☐ Dialysis ☐ Dementia/Memory ☐ Skilled Nursing
  ☐ Subacute Rehab ☐ Psychiatric care

  These units have residents at higher risk for poor outcomes. Vent/trach units provide respiratory support and dementia/memory units are often secured, and limit resident movement to other locations.

Which of the following situations apply to the facility? (Select all that apply)
☐ No cases of COVID-19 currently reported in their community
☐ Cases reported in their community
☐ Sustained transmission reported in their community
☐ Cases identified in their facility (either among HCP and/or residents). If yes, please specify the number of cases among residents ____ and among HCPs _______
☐ Cluster of influenza-like illness (ILI) in facility (either among HCP and/or residents).
  Among residents ____ Among HCPs _______

Have you received any prior information specific to prevention transmission of COVID-19? (Select all that apply)
☐ No
☐ Yes, from the health department
☐ Yes, from Centers for Medicare and Medicaid Services (CMS)
☐ Yes, from another source