

Emergency Department – General Ventilation

1. Do any air handling systems in the emergency department also serve other areas?

Yes \_\_\_ No \_\_\_

If yes, list the other area(s): \_\_\_\_\_  
\_\_\_\_\_

1. Is air that is removed from the emergency department by the air handling system(s) recirculated to other areas?

Yes \_\_\_ No \_\_\_

If yes, list the other area(s): \_\_\_\_\_  
\_\_\_\_\_

If yes, do the air handling system(s) contain HEPA filters or germicidal UV radiation to treat the air prior to recirculation?

HEPA filtration?	Yes ___	No ___
germicidal UV?	Yes ___	No ___

1. Does the emergency department have inward airflow (i.e. negative pressure) relative to all other adjacent indoor areas?

Yes \_\_\_ No \_\_\_ Don't Know \_\_\_

If there is only *inward* airflow to the ED, how has airflow direction been documented? (check all that apply)

Balance reports \_\_\_  
Smoke testing \_\_\_  
Other, please specify \_\_\_\_\_  
\_\_\_\_\_

If there is any *outward* airflow from the ED, list the other area(s) potentially affected:  
\_\_\_\_\_  
\_\_\_\_\_

If there is any *outward* airflow, is the hospital planning modifications to establish inward airflow (i.e. negative pressure) from all adjacent areas?

Yes \_\_\_ No \_\_\_ Not applicable \_\_\_

If yes, anticipated date of completion: \_\_\_\_\_

Patient Cohorting

1. Is there an area of the hospital that can be used or quickly converted to be used for cohorting patients with a potential airborne transmissible disease? (for example: a ward or building with a dedicated air handling system)

Yes \_\_\_ No \_\_\_

If yes, specify the area(s), type of unit (e.g. med/surg, ICU), maximum patient capacity, and whether modification to the air handling or other building systems would be needed:

<u>Area</u>	<u>Type</u>	<u>Max. Pt. Capacity</u>	<u>Modification Needed? (describe)</u>
_____	_____	_____	_____
_____	_____	_____	_____

1. Is the facility planning to modify or create an area that can be used to cohort patients with potential airborne transmissible diseases?

Yes \_\_\_ No \_\_\_

If yes, anticipated date of completion: \_\_\_\_\_

If yes:

<u>Area</u>	<u>Type</u>	<u>Max. Pt. Capacity</u>	<u>Modification Needed? (describe)</u>
_____	_____	_____	_____
_____	_____	_____	_____

Airborne Infection Isolation Rooms

**Please complete the attached line list describing all existing Airborne Infection Isolation Rooms throughout the facility (emergency department, inpatient and outpatient settings).**

1. Is the facility planning to create additional airborne infection isolation rooms in the emergency department?

Yes \_\_\_ No \_\_\_

If yes, number of rooms \_\_\_\_\_ Anticipated date of completion: \_\_\_\_\_

1. Is the facility planning to create additional airborne infection isolation rooms in the inpatient facility?

Yes \_\_\_ No \_\_\_

If yes, number of rooms \_\_\_\_\_ Anticipated date of completion: \_\_\_\_\_

---

Name of Person Completing Form (print) \_\_\_\_\_ Title \_\_\_\_\_

---

Signature

---

Date

---

Phone Number