

Directorate of Health & Family Welfare  
Government of Punjab  
Integrated Disease Surveillance Programme (IDSP)  
Parivar Kalyan Bhawan, Sector-34A, Chandigarh.  
Phone No: 0172-2621506, punjab.idsp@gmail.com



No. IDSP/NHM/Pb/20/4734-4760

Dated: 14/5/2020

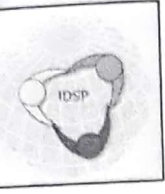
To

1. All the Civil Surgeons, Punjab
2. Principal Govt. Medical College Amritsar, Faridkot and Patiala
3. MS District Hospital Jalandhar and MKH Patiala

**Subject- Regarding Classification of Health Facilities for Covid-19 and Referral Protocols.**

With reference to the subject mentioned above, in continuation of the letter no IDSP /NHM/Pb/20/4049-4075 dated 02-05-2020, the facilities for management of COVID-19 patients are classified as under:-

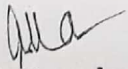
- 1) **Level I :Covid Care Centers(CCC)**-For mild or very mild cases or Covid suspect cases. If any patient admitted in the Covid care center qualifies the clinical criteria for moderate or severe case, such patients will be shifted to the higher level as per Annexure-A. CCC facilities are at places identified by the district administration where medicine, equipment etc will be provided by the Health Department while staff will be recruited from the registered volunteers at the portal. Other essential services would be provided by the district administration.
- 2) **Level II: Dedicated Covid health centers (DCHC)**- For all cases that have been clinically assigned as moderate. These facilities are located in the govt. hospitals and are managed by health department. The cases are monitored on the basis of clinical parameters for assessing severity as per treatment protocol. If any patient qualifies the clinical criteria for severe case, such patient will be shifted to level III as per Annexure B.
- 3) **Level III:Dedicated Covid Hospital (DCH)**- For severe cases. Here ICU beds and ventilators are available for serious cases. These facilities are located in medical colleges and tertiary hospitals.



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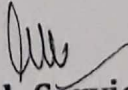
You are requested to follow this notified classification of facilities for Covid-19 patients and the referral protocols, approved by Dr. Rajesh Kumar ED SHSRC, for shifting the patients from level I to level II and from level II to level III for smooth running of these facilities for proper management of COVID-19 positive patients.

  
Director Health Services, Punjab

Endst. No. IDSP/NHM/Pb/20/4761-4787 Dated: 14/05/2020

Copy forwarded to:-

1. PS to Chief Secretary Punjab for information of CS please.
2. PS to PSHFW for information of Principal Secretary Health & family Welfare, Please.
3. PA to MD NHM for information of Mission Director NHM, please.
4. PA to MD PHSC for information of Managing Director, PHSC, please.
5. Director NHM Punjab for information.
6. To all Deputy Commissioners.

  
Director Health Services, Punjab

- **Referral Criteria for referral from COVID Care Centre(Level-I) to Isolation facilities (Level-II) are as follows:-**

1. Any of the following symptoms/signs warrant a shifting to higher centre.

- i. If the patient complains of difficulty in breathing or other symptoms, the patient should be assessed by doctor on duty to decide regarding referral.

- ii. If  $SpO_2 < 95\%$ , on room air.

- iii. If  $RR > 20/\text{min}$

- iv. If  $PR > 100/\text{min}$

- v. If the patient is not alert.

- vi. If any high risk factor is present.

2. Before referring the patient, prior information should be sent to the higher centre where patient is being referred.

3. Referral form should be filled by the doctor present on duty. Referral proforma is attached at Annexure-"G"

4. The record of referred patients should be maintained.

5. Transportation will be provided by District Administration as per the protocol of Isolation and disinfection

# REFERRAL FORM

(From level I to level II)

Name of COVID Care Centre

District

Name of Service Provider

Phone No.

## Patient Details

Name: S/D/W/o: Age(Years)

I.D. No: D.O. Admission Time of Admission

Date of Referral Time of Referral Referred To

### REASON FOR REFERRAL

- 1)
- 2)
- 3)

Vitals of Patient at the time of referral

BP: PR: RR: Temp: SpO<sub>2</sub>

Any Co-morbidity

Signature of Medical Officer

Signature of Senior Medical Officer

**Subject: Revised referral protocol for Covid-19 positive cases from Isolation Facilities to Tertiary Care Facilities(Level II to Level III).**

1) Indications of referral:-

- a. If SpO<sub>2</sub><90% inspite of Oxygen Therapy /NIV (in case of pregnant females if SpO<sub>2</sub><92% and in children if SpO<sub>2</sub><94%)
- b. If there are signs of respiratory distress inspite of Oxygen Therapy /NIV. Tachyphnoa RR>24  
Use of accessory muscles of respiration.  
Abdominal paradox.

2) Before referring the patient, prior information should be sent to the higher centre where patient is being referred. Consent of the higher facility should be taken before referral

3) Apart from above indications , the referral team may take the decision for referral based on:

Their own clinical judgement.

The facilities available at their own institute.

The time to be taken for patient transport to the referred hospital.

4) Referral Form:-

The referral form should be signed by any two of the following:

- SMO incharge of the facility
- Anaesthetist.
- Medical Specialist/ Chest and T.B Specialist.
- DMC (Deputy Medical Commissioner)
- Doctor on duty.

The referral should be verified by Medical Superintendent /Civil Surgeon. If verification is not possible before referral, it can be countersigned after referral.

5) The record of referred patients should be maintained.

6) Transportation of referred patient:-

- a. Patient should be accompanied by trained paramedical staff of the Ambulance.
- b. Oxygen cylinders should be available in the Ambulance.
- c. Ambu Bag/ Bains circuit should be available.
- d. Emergency drugs and resuscitation equipment should be available in the ambulance as per protocol.
- e. Ambulance to be sanitised after every trip.

# REFERRAL FORM

(From level II to level III)

Name of Isolation Facility

District

Name of Service Provider

Phone No.

## Patient Details

Name: S/D/W/o: Age(Years)

I.D. No: D.O. Admission Time of Admission

Date of Referral Time of Referral Referred To

### REASON FOR REFERRAL

1)

2)

3)

Vitals of Patient at the time of referral

BP: PR: RR: Temp: SpO<sub>2</sub>

Any Co-morbidity

Signature 1

Signature 2

Verified by-