Patient should only be admitted if they meet usual clinical criteria for admission. Do not admit suspected COVID-19 with mild symptoms not requiring hospital care.

**Meets any of the following criteria:**
1. Fever (measured or by history, may be intermittent) and cough or dyspnea or
2. Flu-like illness or
3. Diarrhea

**Meets any of the following:**
1. Contact with a confirmed COVID-19 patient and/or
2. Requires supplemental oxygen or intubation

**PUI Path**
1. Place patient in AIIR for aerosolizing procedures
2. Use gowns, gloves, PAPR or N-95 mask and face shield or goggles
3. Send influenza test
4. Chest CT or CXR if pregnant to be obtain in route to inpatient unit

**Influenza Positive**
- Treat for Influenza; Droplet Plus Isolation for aerosolizing procedures

**Influenza Negative**
- Enter admission orders (while awaiting COVID-19 testing):
  1. Droplet plus as above
  2. Obtain the following labs if not performed in the ED:
     a. Procalcitonin, CBC w/diff, LDH, ferritin, D-dimer, ESR/CRP and comprehensive metabolic panel
     b. Check urine legionella + pneumococcal antigen
     c. Obtain Respiratory Pathogen Panel (RPP)

**Influenza Positive**
- Positive for Pathogen consistent with illness. Treat/isolate as indicated.

**Positive COVID result = ID consult. Consult to be entered by house supervisor**

Cessation of Isolation to be decided by IP+C in conjunction with Infectious Disease

**Characteristic findings with COVID-19:** (may not be present early in disease)
- Patient typically have worsening respiratory symptoms in second week (day 8 or 9)
- Lab findings: normal or low procalcitonin
- Normal or low WBC
- Low lymphocytes
- Elevated LDH, ESR, CRP and/or d-dimer
- Elevated ALT and/or Tbil

Not all of above present in early infection

Chest CT often shows bilateral and peripheral ground-glass and consolidative pulmonary opacities; infiltrates more likely later in disease (day 6 or later)
This guidance is based on current information.

- Always use clinical judgment.
- If strong clinical suspicion of COVID-19, avoid aerosolizing procedures. Consider early mechanical ventilation.
- Use conservative fluid management because patients develop ARDS, and excess fluids worsen outcome. See https://jamanetwork.com/journals/jama/fullarticle/2762996

- Due to limited testing resources, testing will be prioritized for the following groups:
  Tier 1:
  - Critically ill patients receiving ICU level care with unexplained viral pneumonia or respiratory failure, regardless of travel history or close contact with suspected or confirmed COVID-19 patients;
  - Any person, including health care workers, with fever or signs/symptoms of a lower respiratory tract illness and close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset;
  - Any person, including health care workers, with fever or signs/symptoms of a lower respiratory tract illness and a history of travel within 14 days of symptom onset to geographic regions where sustained community transmission has been identified.

  Tier 2:
  - Hospitalized (non-ICU) patients and long-term care residents with unexplained fever and signs/symptoms of a lower respiratory tract illness. The number of confirmed COVID-19 cases in the community should be considered. As testing becomes more widely available, routine testing of hospitalized patients may be important for infection prevention and management at discharge.

  Tier 3:
  - Patients in outpatient settings who meet the criteria for influenza testing. This includes individuals with co-morbid conditions including diabetes, COPD, congestive heart failure, age >50, immunocompromised hosts among others. Given limited available data, testing of pregnant women and symptomatic children with similar risk factors for complications is encouraged. The number of confirmed COVID-19 cases in the community should be considered.

  Tier 4:
  - Community surveillance as directed by public health and/or infectious diseases authorities.