Services de santé du TIMISKAMING Health Unit

COVID-19 Screening Form

Rev. 2020-05-06

Please fax this form to 705-647-5779

**Please use this form to report potential cases in accordance with sector specific guidance documents.*

CLIENT INFORMATION (Or affix patient label)			
Last Name:	First Name:		Gender:
Phone #:	Health Card Number:	DOB (dd/mm/yyyy):	
Address:	City:		Postal Code:
Primary Healthcare Provider:			

TESTING INDICATIONS (*reminder to indicate STAT on bag and form)

- ☐ Relevant travel
  Travel date(s): _____
- ☐ Hospital inpatient
- ☐ Resident living or staff working in Long-Term Care Home
- ☐ Resident or staff working in Retirement Home or other Congregate Living Setting and Institution
- ☐ Health care worker / caregiver / care provider / First Responder
- ☐ Person living in the same household of Health care worker / caregiver / care provider / First Responder
- ☐ Resident of remote / isolated / rural / indigenous communities
- ☐ Specific Priority Populations (Individual with frequent healthcare system interactions)
- ☐ Worker at an essential workplace
- ☐ Cross-border worker
- ☐ Other: _____

Are you receiving Home and Community Care Services?

- ☐ Yes (specify): _____
- ☐ No

INTERVENTIONS

- ☐ Self-isolating
- ☐ Self-monitoring
- ☐ Provide self-isolation / self-monitor instructions
- ☐ Patient hospitalized
  Location: _____
  Date: _____
- ☐ Location: _____
- ☐ Lab test submitted date: _____

Reporting HCP: _____ Date: _____

SYMPTOMS

Date of onset of first symptoms (dd/mm/yyyy): _____

☐ Fever (37.8 or higher)	☐ Hoarse voice	☐ Atypical Symptoms**
☐ Cough	☐ Difficulty swallowing	☐ Other, Specify:
☐ Shortness of breath	☐ Loss of sense of smell or taste	_____
☐ Runny nose/sneezing*	☐ Nausea/vomiting	_____
☐ Nasal congestion*	☐ Diarrhea	
☐ Sore throat	☐ Abdominal pain	☐ No symptoms

* Note: in patients **presenting with ONLY** runny nose/sneezing or congestion, consideration should be given to other underlying reasons for these symptoms such as seasonal allergies and post-nasal drip.

** **Atypical symptoms** include: unexplained fatigue/malaise, delirium (acutely altered mental status and inattention), unexplained or increased number of falls, acute functional decline, exacerbation of chronic conditions, chills, headaches, croup, conjunctivitis. Atypical presentations should be considered, particularly in children, older persons, and people living with a developmental disability.

OCCUPATIONAL/ RESIDENTIAL EXPOSURES

☐ Health Care Staff

If yes, with direct patient contact?

☐ Yes ☐ No ☐ Unknown

Facility: _____

☐ Daycare worker/attendee

Location: _____

☐ Resident/staff of a Long-Term Care facility
Facility: _____

☐ Resident/staff of a Congregate Living facility
Facility: _____

☐ Miner

☐ Other (i.e. EMS):_____

CLIENT RISK FACTORS

☐ Diabetes	☐ Cardiac Conditions	☐ Other:
☐ COPD	☐ Immunocompromised	

MOST LIKELY EXPOSURE/NOTES:

THU USE ONLY:

☐ High Risk	☐ Confirmed	☐ Referred to:_____
☐ Medium Risk	☐ Probable	☐ Testing recommended
☐ No/Low Risk	☐ Person Under Investigation	☐ Testing not recommended
	☐ Contact	
	☐ Does not meet	

Nursing Signature: _____ Date:_____