Services de santé du TIMISKAMING Health Unit

COVID-19 Screening Form

Rev. 2021-11-11

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: (AS PER HEALTH CARD)	First Name: (AS PER HEALTH CARD)	Gender:
Home Phone #:	Health Card Number:	DOB (dd/mm/yyyy):
Cell Phone #		
Address:	City:	Postal Code:
Primary Healthcare Provider:	EMAIL ADDRESS:	

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

- ☐ Relevant travel
  Travel date(s): _____
- ☐ Hospital inpatient
- ☐ Resident/Care provider living in the same home/ First responder or staff working in LTCH or Retirement Home or Other Congregate Living Setting
- ☐ 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
- ☐ Asymptomatic
- ☐ Contact of known case
  ☐ Last Day of Exposure (dd/mm/yyy) _____
- ☐ Day 7 swab – Date (dd/mm/yyyy) _____
- ☐ School / Childcare Attendee
- ☐ Other: _____
- ☐ Rapid Antigen Positive Test (ie. Panbio)
- ☐ PoC Rapid Molecular Test (ie. ID NOW)
  ☐ Positive ☐ Negative (if available)

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)	☐ Difficulty swallowing	☐ Atypical Symptoms**
☐ Cough	☐ Loss of sense of smell or taste	☐ Other, Specify:
☐ Shortness of breath	☐ Nausea/Vomiting	
☐ Runny nose *	☐ Diarrhea	_____
☐ Nasal congestion*	☐ Abdominal pain	
☐ Sore throat	☐ Dizziness	☐ No symptoms
☐ Chest Pain/Tightness	☐ Ear ache	
☐ Sneezing	☐ Joint Pain/Arthralgia	

* Note: in patients **presenting with ONLY** runny nose 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, multisystem inflammatory vasculitis (children). 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:

VACCINATION STATUS**:** _____

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	
	☐ Surveillance	

Signature: _____ Date:_____