Services de santé du TIMISKAMING Health Unit

COVID-19 Screening Form

For use until April 30

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:			

HIGH PRIORITY GROUPS (*reminder to indicate STAT on bag and form)

- ☐ Travel outside of Canada within 14 days prior to onset of illness & clinical symptoms
- ☐ Travel to urban centre where community transmission is suspected

Travel date(s): _____

- ☐ Close contact with symptomatic person who has traveled outside of Canada
- ☐ Close contact with confirmed or probable case
- ☐ Symptomatic members of remote, isolated rural and/or Indigenous communities
- ☐ Health care workers and staff who work in health care facility*
- ☐ Index symptomatic person of a close contact to a HCW
- ☐ Individuals with respiratory illness who reside or work in long term care homes or retirement homes*
- ☐ Hospitalized patients admitted with respiratory symptoms*
- ☐ First Responders
- ☐ Care Givers
- ☐ Other: _____

INTERVENTIONS

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

Reporting HCP: _____ **Date:** _____

Additional Information (if available)

SYMPTOMS

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

- ☐ **Fever (37.8 or higher)**
- ☐ Feverish (temp not taken)
- ☐ **Cough**
- ☐ Sputum production
- ☐ Headache
- ☐ **Runny nose/nasal congestion**
- ☐ **Sore throat/hoarse voice**
- ☐ Difficulty swallowing
- ☐ Swollen Lymph nodes
- ☐ Sneezing
- ☐ Runny nose
- ☐ Conjunctivitis
- ☐ Otitis
- ☐ **Loss of sense of smell or taste**
- ☐ **Fatigue/prostration**
- ☐ Malaise
- ☐ Chills
- ☐ **Myalgia/muscle pain**
- ☐ Arthralgia/joint pain
- ☐ **Shortness of breath/ Difficulty breathing**
- ☐ Chest Pain
- ☐ Anorexia/loss of appetite
- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Difficulty swallowing**
- ☐ **Diarrhea**
- ☐ Abdominal pain
- ☐ Nose bleed
- ☐ Rash
- ☐ Seizures
- ☐ Dizziness
- ☐ Other, Specify: _____
- ☐ No symptoms

OCCUPATIONAL / RESIDENTIAL EXPOSURES

- ☐ Health Care Worker or volunteer
  If yes, with direct patient contact?
  ☐ Yes ☐ No ☐ Unknown
  Facility(s): _____
- ☐ Laboratory worker handling biological specimens
- ☐ School or daycare worker/attendee
  Location: _____
- ☐ Resident of a retirement residence or long term care facility.
  Facility: _____
- ☐ Resident in an institutional facility
  Facility: _____
- ☐ Veterinary worker
- ☐ Farm Worker
- ☐ Other (i.e. EMS): _____

CLIENT RISK FACTORS

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

MOST LIKELY EXPOSURE/NOTES:

THU USE ONLY:

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

Nursing Signature: _____ Date: _____