Screening

Field	Options
Does the patient have any one of the following signs or symptoms?	☐ None ☐ Fever ☐ Cough ☐ Shortness of breath
Symptom Onset Date	****/**/**
Has the patient traveled anywhere outside of Canada in the last 14 days?	○ Yes ○ No ○ Refused to answer ○ Unknown
Country of Travel	
Date of Return	****/**/**
Comments	
Has the patient been in close contact with a symptomatic confirmed or probable case in the last 14 days?	○ Yes ○ No ○ Unknown
Date of last contact	****/**/**
Sustained contact	○ Yes ○ No ○ Unknown
Contact Setting	☐ Healthcare setting ☐ Family setting ☐ Workplace ☐ Unknown ☐ Other:
Comments	
Has the patient been in close contact with a person with fever and/or cough who has been to an affected area in the last 14 days?	○ Yes ○ No ○ Unknown
Date of last contact	****/**/**
Contact Setting	☐ Healthcare setting ☐ Family setting ☐ Workplace ☐ Unknown ☐ Other:
Comments	
In the 14 days prior to symptom onset, did the patient visit any health care facility?	○ Yes ○ No ○ Unknown
Patient employment/living situation	☐ Healthcare worker/volunteer with direct patient contact ☐ Other: ☐ Laboratory worker handling biological specimens ☐ Veterinary/animal worker ☐ School or daycare worker/attendee ☐ Farm worker ☐ Resident of long-term care facility/institutional facility
Patient probable for COVID	○ Yes ○ No

Vital Signs

Temperature	oral	DegC	axilla	DegC	tympanic	DegC	rectal	DegC	temporal	DegC
Pulse	bpm									
Blood Pressure	mmHg	/	mmHg							
Respiratory Rate	br/min									
O2 Sat	%									

Symptom Assessment

	Yes	No	Unknown	Comment
Cough				
Fever (greater or equal to 38C)				
Feverish/chills (unknown temperature)				
Sore Throat				
Runny Nose				
Shortness of breath/difficulty breathing				
Nausea/Vomiting				
Anorexia/Decrease Appetite				
Headache				
General Weakness				
Pain (muscular, chest, abdominal, joint, etc)				
Irritability/Confusion				
Diarrhea				
Other Symptom				

Symptom Comments

Education Provided
- ☐ How to self-monitor
- ☐ How to self-isolate
- ☐ Self-isolation for caregivers
- ☐ Other:

Disposition
- ○ Home
- ○ Emergency department with EMS
- ○ Emergency department
- ○ Urgent Care
- ○ Primary care follow up
- ○ Other:

Pre-Existing Conditions and Risk Factors

	Yes	No	Unknown	Comment
Cardiac Disease				
Chronic neurological or neuromuscular disorder				
Diabetes				
Immunodeficiency disease/condition				
Liver Disease				
Malignancy				
Post-Partum (less than 6 weeks)				
Pregnancy				
Renal Disease				
Respiratory Disease				
Other				

Provider Assessment

Name of Provider					
Level of Consciousness/Orientation	☐ Awake	☐ Alert	☐ Oriented	☐ Other:	
General Appearance	○ Well	○ Unwell	○ Other:		
Breath Sounds	☐ Clear	☐ Good air entry bilaterally	☐ Other:		
Respiratory Pattern	☐ Regular	☐ Asymmetrical	☐ Laboured	☐ Other:	
Anterior/Posterior					
Appetite	○ Good	○ Poor	○ Other:		
Fluid Intake	○ Good	○ Poor	○ Other:		
Urine Output	○ Normal	○ Low	○ Other:		
Other Symptoms	☐ Chest pain	☐ Shortness of breath	☐ Nausea and/or vomiting	☐ Other:	

Provider Assessment

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