Indigenous Services Canada | Services aux Autochtones Canada | Canada

# COVID-19 Screening & Testing Form

**NOTICE TO RECIPIENT OF HEALTH INFORMATION**

As required by Section 42 of the *Health Information Act*, the individually identifying diagnostic, treatment and care information being disclosed to you by our agency is being disclosed to you under the authority of the *Health Information Act*. The health information being provided to an individual who is responsible for providing continuing treatment and care to the individual who is the subject of the information as per Sec. 35(1)(b). This information can only be used for the purposes of providing health services (including obtaining payment for these services) for the individual who is the subject of this information.

Date and Time:

_____

## Client Information:

| | | | |
|---|---|---|---|
| Client's Surname: | | Date of Birth: | D D / M M / Y Y |
| Given Names: | | Gender: | M ☐ F ☐ |
| Client Address: | | Phone Number: | |
| Client DIAND #: | | AB Health #: | |

## SCREENING

### Testing Criteria Guidelines

Individuals who are prioritized for testing include:

- ☐ **Any person who is symptomatic***
- ☐ **All close contacts** of confirmed COVID-19 cases,*** symptomatic or not**
- ☐ **All persons linked to a known outbreak, symptomatic or not**
- ☐ **Individuals or groups identified as a priority under the authority of the FNIHB Medical Officer of Health**

### A. RISK ASSESSMENT: SCREENING QUESTIONS

| **1. Is the client experiencing any of the following:** | **YES** | **NO** |
|---|---|---|
| Severe difficulty breathing (e.g., struggling for each breath, speaking in single words) | | |
| Severe chest pain | | |
| Having difficulty waking up | | |
| Feeling confused | | |
| Loss of consciousness | | |

If **YES** to **ANY** of the above call 911 or local ambulance for patient transport to emergent care

| **2. Is the client experiencing any of the following:** | **YES** | **NO** |
|---|---|---|
| Shortness of breath at rest | | |
| Inability to lie down because of difficulty breathing | | |
| Chronic health conditions that you are having difficulty managing because of your current respiratory illness | | |
| If yes, please specify: | | |

If **YES** to **ANY** of the above contact and follow-up with a health care professional to be assessed

| **3. If the client is an adult, in the past 10 days, has he/she experienced any of the following:** | **YES** | **NO** | **Date of Symptom Onset** |
|---|---|---|---|
| Fever (greater than 38 degrees Celsius) | | | |
| New onset of (or exacerbation of chronic) cough | | | |
| New onset or worsening shortness of breath | | | |
| Runny nose | | | |
| Sore Throat | | | |

If **YES**(s) to **ANY** of the above, you are **legally required to isolate** and schedule an appointment for a **COVID-19 Test.**

| **4. If the client is a child, in the past 10 days, has he/she experienced any of the following:** | **YES** | **NO** | **Date of Symptom Onset** |
|---|---|---|---|
| Fever (greater than 38 degrees Celsius) | | | |
| New onset of (or exacerbation of chronic) cough | | | |
| New onset or worsening shortness of breath | | | |
| Loss of sense of taste or smell | | | |

If **YES**(s) to **ANY** of the above, you are **legally required to isolate** and, schedule an appointment for a **COVID-19 Test.**

| **5. In the past 10 days, has the client (child or adult) experienced any of the following:** | **YES** | **NO** | **Date of Symptom Onset** |
|---|---|---|---|
| Chills | | | |
| Painful swallowing | | | |
| Headache | | | |
| Muscle or joint ache | | | |

| | | | |
|---|---|---|---|
| Feeling unwell, fatigue or severe exhaustion | | | |
| Nausea, vomiting, diarrhea, or unexplained loss of appetite | | | |
| Loss of sense of smell or taste | | | |
| Conjunctivitis (pink eye) | | | |

If **YES**(s) to **ANY** of the above, you are **recommended** to schedule an appointment for a **COVID-19 Test**.

| **6. Does the client work or go to:** | **YES** | **NO** | **Date of Last Shift** |
|---|---|---|---|
| As a healthcare worker (in primary care, continuing care, supportive living, pharmacy, hospital, home care, diagnostic imaging, laboratory facility or setting) | | | |
| As a COVID-19 enforcement worker or first responder (e.g. security, police officer, peace bylaw officer, environmental health officer, fish/wildlife officer, EMS or medical first responder, firefighter) | | | |
| With home care, group home, disability support or shelter clients | | | |
| At a correctional facility | | | |
| At a school or daycare facility that is currently experiencing an outbreak | | | |
| In an area of a supportive living or long-term care facility that is currently experiencing an outbreak | | | |

If **YES**(s) to either of the **LAST TWO QUESTIONS,** you are **recommended** to schedule an appointment for a **COVID-19 Test**.

| **7. Does the client reside in a:** | **YES** | **NO** |
|---|---|---|
| First Nation community in Alberta | | |
| Home with members who are immunocompromised, over 60 years old, or have underlying health conditions | | |
| Long-term care facility or supportive living facility | | |

| **8. In the past 14 days, has the client:** | **YES** | **NO** |
|---|---|---|
| Returned from travel outside of Canada | | |
| Come into close contact (within 2 meters or 6 feet) with a person: | | |
| Who is a confirmed case of COVID-19 | | |
| With respiratory symptoms and is a close contact with someone who is a confirmed case of COVID-19 | | |
| With respiratory symptoms and is a close contact with someone who returned from travel outside of Canada in the 14 days before they became sick | | |
| Had laboratory exposure to biological material (e.g. primary clinical specimen) known to contain COVID-19 | | |

If **YES** to **ANY** of the above, please provide teaching on mandatory **isolation and quarantine**. You are **eligible to be tested** for COVID-19.

## B. TESTING INFORMATION

| | **YES** | **NO** |
|---|---|---|
| Lab Requisition Completed with client information | | |
| COVID-19 testing has been scheduled for: (Please Check) | | |

☐ In Clinic ☐ In Home ☐ Drive-thru

Appointment Date: D D / M M / Y Y

## C. CLIENT EDUCATION

| **Were education or resources provided for :** | **YES** | **NO** |
|---|---|---|
| General Information about COVID-19 | | |
| Self-isolation, Social distancing, or Physical distancing | | |
| Hand Hygiene | | |
| Respiratory Etiquette | | |
| Mental Health | | |

## D. SCREENING COMPLETED BY:

| Name and Designation: | Signature: | Date: D D / M M / Y Y |
|---|---|---|
| | | |

# TESTING

**A. Location of Testing (Please Check)**

☐ In Clinic ☐ In Home ☐ Drive-thru

**B. Date/Time of Testing:**

| Date of Testing: D D / M M / Y Y | Time of Testing : |
|---|---|

**C. Results of Testing (Please Circle):** Positive Negative

**D. Date/Time result received by Client:**

| Date of Testing: D D / M M / Y Y | Time of Testing : |
|---|---|

**E. Provide Teaching on Mandatory Isolation and Quarantine Guidelines**

**Albertans who have core symptoms*:**

- Anyone with the core symptoms that is not related to a pre-existing illness/condition MUST isolate immediately for a minimum of **10 days** from the start of symptoms or until the symptoms resolve, whichever is longer.

**Albertans who have travelled outside of Canada:**

- Anyone who has returned from travel outside of Canada in the past 14 days MUST quarantine for **14 days**. If they develop **symptoms** during this time, they must isolate for an **additional 10 days** from the beginning of symptoms or until they are feeling well, whichever takes longer.

**Albertans who are close contacts** with a confirmed*** case of COVID-19:**

- Anyone who is a close contact with a confirmed case of COVID-19 MUST quarantine for **14 days**. If they develop **symptoms** during this time, they must isolate for an **additional 10 days** from the beginning of symptoms or until they are feeling well, whichever takes longer.

**Albertans who test positive for COVID-19:**

- Anyone who test positive for COVID-19 MUST isolate for minimum of **10 days** from the start of symptoms or until the symptoms resolve, whichever is longer. **Healthcare workers** who test positive may not work in any healthcare facility until **14 days** have passed since the beginning of symptoms and symptoms have resolved, whichever is longer.

*Please note definitions:*

***Core Symptoms** related to COVID-19 for **adults** are new onset/exacerbation of fever (over 38 degrees Celsius), cough, shortness of breath, sore throat, and runny nose

***Core Symptoms** related to COVID-19 for **children under 18** are new onset/exacerbation of fever (over 38 degrees Celsius), cough, shortness of breath or difficulty breathing, and loss of sense of taste or smell

Expanded criteria includes: chills, painful swallowing, stuffy nose, headache, muscle/joint ache, feeling unwell, fatigue, severe exhaustion, nausea, vomiting, diarrhea or unexplained loss of appetite, loss of sense of smell or taste, conjunctivitis (pink eye)

***Asymptomatic** refers to individuals who never develop symptoms or whose symptoms went unnoticed

****Close contact** is an individual who:

- Provides care, lives with, or has close physical contact without appropriate use of personal protective equipment

  OR
- Comes into direct contact with infectious body fluids

  OR
- Comes within 2 metres of them for more than 15 minutes

*****Confirmed case** is an individual with laboratory confirmation of infection with the virus (SARS-CoV-2) that causes COVID-19:

- Detection of at least one specific gene target by nucleic acid amplification tests (NAAT) at a Provincial Public Health Laboratory where NAAT tests have been validated. This includes the Simplexa, GeneXpert, or BD Max NAT where additional testing is not necessary.

  OR
- Has a confirmed positive result by National Microbiology Lab (NML) by NAAT

******Probable case** is an individual who:

- Had NO laboratory testing done AND has symptoms who is a close contact to a lab-confirmed COVID-19 case

  OR
- Had laboratory testing done AND has symptoms who meets the COVID-19 exposure criteria***** AND whose laboratory diagnosis of COVID-19 is inconclusive

*******Exposure criteria** includes an individual who in the 14 days before the onset of symptoms:

- Has travelled outside of Canada

  OR
- Is a close contact with a symptomatic traveller who returned from travel outside of Canada in the previous 14 days

  OR
- Was involved in a COVID-19 outbreak or cluster

  OR
- Has had laboratory exposure to biological material known to contain COVID-19)

**F. Reinforce Teaching on how to Reduce the Spread of COVID-19**

- Do not visit a hospital, physician's office, lab, or healthcare facility without consulting Health Link **(811)** first, unless it is an emergency
- Avoid non-essential travel, practice physical distancing (e.g. 2 metres/6 feet), and wear a non-medical mask in public
- If able to, self-isolate in a separate room and bathroom. If unable to, ensure that there is two meter distance between the client and others and that the bathroom be sanitized after each use.
- Wash hands often with soap and water and/or use an alcohol-based hand rub for at least 20 seconds.
- Avoid close contact with other people with chronic conditions, compromised system, seniors, or people with acute respiratory infections
- If COVID-19 symptoms do develop during the self-isolation period, they should contact a health care professional to be reassessed

**Client Name:** _____

**Date and Time:** _____

# COVID-19 Assessment Form

## ASSESSMENT

**A. CLINICAL FINDINGS** (If screening was done on the same day, please proceed to part B)

**1. Onset Date:** D D / M M / Y Y

**2. Does the client have any of the following** (Please check all that apply):

| | | | |
|---|---|---|---|
| ☐ Fever | ☐ Chills | ☐ Gastrointestinal symptoms including: Nausea, vomiting, or diarrhea | ☐ Dizziness |
| ☐ Cough | ☐ Headache | ☐ Loss of sense of smell or taste | ☐ Irritability/confusion |
| ☐ Shortness of breath | ☐ Muscle or joint aches | ☐ Conjunctivitis or pink eye | ☐ Sneezing |
| ☐ Difficulty breathing | ☐ Feeling unwell in general, new fatigue, or severe exhaustion | | ☐ Nosebleed |
| ☐ Runny or stuffy nose | ☐ Painful swallowing | | ☐ Chest pain |
| ☐ Sore throat | | | ☐ Asymptomatic |
| | | | ☐ Other, specify: |

**B. PAST MEDICAL HISTORY AND RISK FACTORS**

**1. Does the client have any of the following** (Please check all that apply):

| Systems Assessment | Other Underlying Conditions | Substance Use |
|---|---|---|
| ☐ Neurological/Neuromuscular disorder | ☐ Anemia/hemoglobinopathy | ☐ Alcohol |
| ☐ History of seizures (including epilepsy) | ☐ Malignancy | ☐ Non-prescription medication(s) |
| ☐ Cardiovascular disease | ☐ Obesity | ☐ Prescription medication(s) |
| ☐ Hypertension | ☐ Pregnant EDD: D D / M M / Y Y | ☐ Illegal substances (e.g. drugs) |
| ☐ Metabolic disease | ☐ Postpartum | ☐ Smoking |
| ☐ Diabetes | ☐ Other, specify: | ☐ Current smoker (smoked in last 30 days) |
| ☐ Chromosomal disease | | ☐ Past history of smoking (prior to 30 days) |
| ☐ Respiratory or chronic lung disease | | ☐ Tobacco products (e.g. cigarettes, cigars, hookah, pipe) |
| ☐ Asthma | | ☐ Cannabis |
| ☐ Chronic obstructive pulmonary disease | | ☐ Vaping: Nicotine-free |
| ☐ Hepatic disease | | ☐ Vaping: Nicotine |
| ☐ Renal disease | | ☐ Other, specify: |
| ☐ Gastrointestinal disease | | |
| ☐ Immunodeficiency disease | | |

**C. MENTAL HEALTH ASSESSMENT**

| 1. Is the client experiencing any of the following: | YES | NO | Details |
|---|---|---|---|
| Little interest or pleasure in doing things | | | |
| Trouble concentrating | | | |
| Feeling down, depressed, or hopeless | | | |
| Difficulty falling asleep, staying asleep, or sleeping too much | | | |
| Feeling tired or having little energy | | | |
| Poor appetite or overeating | | | |
| Feeling worried, anxious, or scared/fearful | | | |
| Other, specify: | | | |

**D. VITAL SIGNS** (Please use your best clinical judgment to determine whether this is indicated)

| BP: | HR: | RR: | O2 Sat %: | Temp: |
|---|---|---|---|---|
| | | | | |

**E. FOLLOW-UP AND OTHER NOTES:**

| |
|---|
| |
| |
| |

**F. ASSESSMENT COMPLETED BY:**

| Name and Designation: | Signature: | Date and Time: | Phone Number: |
|---|---|---|---|
| | | | |