**COVID-19 – Assessment Form**

PATIENT STICKER

Date of symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of COVID test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A +ve -ve

**PUBLIC HEALTH CONTRAINDICATION(S) TO DISCHARGE:**

* Homeless, or no access to food, water, safe shelter or communications*

* Lives with a high-risk individual without ability to self-isolate in home*

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_**

COVID SYMPTOMS

**HPI:**

 *Cough/Sore throat*

**MEDICATION**

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 *Shortness of breath*

 *Fever Coryza*

 *Sore throat*

**HISTORY**

 *Conjunctivitis*

 *Diarrhea*

 *Nausea/vomiting*

 *Anosmia/ Dysgeusia*

 *Rhinorrhea*

**PMH**:

* Known COVID19 contact*

RISK FACTORS

*If HCW PPE Yes  No*

* Sick contacts*

*Chronic Lung Disease*

* Immunosuppression/Cancer*

* Diabetes mellitus*

* Cardiovascular Disease*

* Hypertension*

* Cerebrovascular Disease*

* Smoking history (current)*

* HCW  1st responder*

* 1st nation on reserve*

* LTC/RH/Shelter resident*

* Group home/Corrections resident*

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**PHYSICAL EXAM: Time \_\_\_\_\_\_\_\_\_\_\_**

BP \_\_\_\_\_\_\_\_\_\_ HR \_\_\_\_\_\_ RR \_\_\_\_\_\_ Temp \_\_\_\_\_\_

SpO2 \_\_\_\_\_% ( R/A or \_\_\_\_\_L 02)

Ambulatory SpO2 \_\_\_\_\_\_\_\_\_\_ Cannot walk (new)

RED FLAGS

 HR>110

 RR>30

 SBP<95

 SpO2 <92%R/A

 Resp distress

 Chest pain

 Decline in function (new)

 Dizziness/presyncope (new)

 GCS< 14

 New confusion

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**INVESTIGATIONS**

**DISPOSITION/PLAN**:

 Discharge home  Discharge home with follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Transfer to Emergency. Reason for transfer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prescription. (Details)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (yyyy/mm/dd): \_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reg. No.: \_\_\_\_\_\_\_\_\_\_