Provincial Health Services Authority
Province-wide solutions. Better health.

Providence HEALTH CARE

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Place Patient Label Here

COVID-19
PRE-ADMISSION / ADMISSION ASSESSMENT

* 8 4 8 0 *

Interdisciplinary Assessment

INITIAL SCREENING: ☐ Unable to obtain patient history → **Go to Physician Screen section on page 2**

RISK FACTORS FOR COVID-19 EXPOSURE

In the last 14 days:			
Has patient been in close contact with anyone diagnosed with lab confirmed COVID-19?	☐ No	☐ Yes	When? Date: _____
Has patient lived or worked in a setting that is part of a COVID-19 outbreak?	☐ No	☐ Yes	When? Date: _____
Has patient been advised to self-isolate or quarantine at home by Public Health?	☐ No	☐ Yes	Contact info: _____
Has patient returned from travel outside of Canada?	☐ No	☐ Yes	Return date: _____ Travel location: _____
Comments:			

DOES THE PATIENT HAVE NEW ONSET, COVID-19 LIKE SYMPTOMS IN THE LAST 14 DAYS?

PRE-SCREEN - 24 to 72 hours prior to admission / visit / surgery Date/Time: _____ ☐ N/A		
Fever	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Runny nose/nasal congestion	☐ Yes	☐ No
Loss of sense of smell	☐ Yes	☐ No
Sore throat or painful swallowing	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Nausea and/or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Patient referred for testing	☐ Yes	☐ No
Support person asymptomatic	☐ Yes ☐ N/A	☐ No
Signature: _____		
Printed name: _____		
Designation: _____		

DAY OF ADMISSION SCREEN – On arrival / Day of surgery Date/Time: _____		
Fever	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Runny nose/nasal congestion	☐ Yes	☐ No
Loss of sense of smell	☐ Yes	☐ No
Sore throat or painful swallowing	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Nausea and/or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Patient referred for testing	☐ Yes	☐ No
Support person asymptomatic	☐ Yes ☐ N/A	☐ No
Signature: _____		
Printed name: _____		
Designation: _____		

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Interdisciplinary Assessment

PHYSICIAN/SURGEON SCREEN:

COVID-19 NP test performed	☐ No ☐ Yes	Date: _____ Result: ☐ Negative ☐ Positive
If test has not been performed, do you recommend testing patient?	☐ No ☐ Yes	Reason:
☐ Unable to perform swab	Reason:	

Screened by:

Signature | Printed name | Date/Time

FINAL TEAM ASSESSMENT:

COVID-19 risk factor (travel, contact, outbreak)	☐ Yes ☐ No ☐ Unknown
COVID-19 like symptoms that cannot be explained by another medical or surgical diagnosis	☐ Yes ☐ No ☐ Unknown
COVID-19 test result	☐ Positive ☐ Negative ☐ Unknown/Pending ☐ N/A
Comments:	

Confirm Patient Risk Category: (refer to table below)

☐ GREEN ☐ **YELLOW** ☐ **RED**

PATIENT RISK CATEGORY TABLE:

COVID-19 Risk Factors	COVID-19 Symptoms	COVID -19 Test Results	COVID -19 RISK CATEGORY
No	No	Not required	GREEN
No	No	Negative	GREEN
Yes	No	Negative	GREEN
No	Unknown	Negative	GREEN
No	Yes	Negative	GREEN
Yes	Yes	Negative	GREEN
Unknown	Unknown	Unknown/pending	**YELLOW**
Yes	No	Unknown/pending	**RED**
No	Yes	Unknown/pending	**RED**
Yes	Yes	Unknown/pending	**RED**
-	-	**POSITIVE**	**RED**