Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN

Administrative Gender ☐ Male ☐ Female ☐ Non-binary/prefer not to disclose (X) ☐ Unknown

COVID-19 Continuing Care Resident Screening Tool

Indicate present or worsening symptom(s) by placing check marks ✓ in daily boxes for D (day) and/or E (evening). Leave box blank if no symptoms. Initials for D and E indicate that all resident screening questions have been asked. Record more details of symptoms in Progress Notes, follow isolation protocols and report changes in symptoms to RN or LPN. Increase frequency of screening to a minimum of twice daily when outbreak of COVID-19 is confirmed.

Month: Year:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Fever *(37.8°C or higher)* / Temperature *(record value)*	D																															
	E																															
Respiratory Cough	D																															
	E																															
Shortness of Breath/ Difficulty Breathing	D																															
	E																															
Runny Nose/Sneezing/ Nasal Congestion/Stuffy Nose	D																															
	E																															
Hoarse Voice/ Sore Throat/ Difficulty/Painful Swallowing	D																															
	E																															
Atypical Altered Mental State	D																															
	E																															
Conjunctivitis	D																															
	E																															
Headaches	D																															
	E																															
Muscle or Joint Aches Chills	D																															
	E																															
Nausea/Vomiting/Diarrhea/ Unexplained Loss of Appetite	D																															
	E																															
Feeling Unwell/Fatigue/ Malaise/Severe Exhaustion	D																															
	E																															
Loss of Sense of Smell or Taste	D																															
	E																															
Other *(document details in Progress Notes)*	D																															
	E																															
Initials (Day)																																
Initials (Evening)																																

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Additional Screening Have you travelled outside of Canada in the last 14 days OR have you had close contact with anyone showing symptoms who has travelled outside of Canada in the last 14 days?	D																															
	E																															
Have you had close contact (face-to-face contact within 2 metres or 6 feet) with someone who is ill with cough and/or fever **in the last 14 days without** the use of appropriate PPE?	D																															
	E																															
Have you had close contact (face-to-face contact within 2 metres or 6 feet) **in the last 14 days** with someone who is being investigated or confirmed to be a case of COVID-19 **without** the use of appropriate PPE?	D																															
	E																															
Initials (Day)																																
Initials (Evening)																																