

Ambulatory Care Communicable Disease Screening

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

All sections must be **fully assessed** and completed.

For more information see the [IPC COVID-19 Interim Recommendations](#)

Part 1 - Patient Current Status	
<input type="checkbox"/> Unable to assess patient's symptoms due to patient's physical or mental status. Implement Modified Respiratory Precautions. Use usual process for COVID-19 testing of outpatients.	
Part 2 - Symptom Set Assessment within the last 7 days Review ALL symptom sets and follow actions required as appropriate.	Actions Required
<input type="checkbox"/> Respiratory/Core Symptoms (new or worse): Cough Shortness of breath Difficulty breathing Increased O ₂ requirement/decreased O ₂ saturation Sore throat/painful swallowing/hoarse voice Runny nose/nasal congestion/sneezing Fever/chills/rigors: Adult: higher than 37.8° C; Pediatrics: 38° C or higher (If sole symptom, should be reviewed with other symptoms, history, physical exam, etc.) Loss of/change to sense of smell or taste Neonates: also consider apnea <input type="checkbox"/> Gastrointestinal (GI) Symptoms (new or worse): Vomiting and/or diarrhea	If Respiratory/Core or GI symptoms present Defer appointment/procedure if possible. OR Implement Modified Respiratory Precautions due to symptoms. Use usual process for COVID-19 testing/other investigations in outpatients.
Pertussis Symptoms <input type="checkbox"/> Cough AND one or more other Pertussis Symptoms Paroxysms, inspiratory 'whoop' cough ending in gagging/vomiting Neonates: also consider apnea	If checked: Defer appointment/procedure if possible. OR Implement Modified Respiratory Precautions due to symptoms. Use usual process for COVID-19 and Pertussis testing/other investigations in outpatients.
Tuberculosis (TB) Symptoms <input type="checkbox"/> Cough AND any other Tuberculosis (TB) Symptoms Hemoptysis, fever, night sweats, unintentional weight loss, or history of TB Measles and Varicella Symptoms <input type="checkbox"/> Fever AND Rash, AND International travel in last month <input type="checkbox"/> Fever AND Rash AND potential Measles Exposure <input type="checkbox"/> Fever AND Rash AND potential Varicella Exposure	If checked Airborne Isolation room preferred. If unavailable then use private room with door closed. Implement Airborne and Modified Respiratory Precautions ASAP (<i>ensure door is closed</i>). Notify physician and/or MRHP for further assessment. Defer appointment/procedure if appropriate.
<input type="checkbox"/> No Respiratory/Core or GI symptoms present: Follow Routine Practices	

Continue to Part 3

**Ambulatory Communicable (*Respiratory*)
Disease Screening**

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Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB (<i>dd-Mon-yyyy</i>)	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male		<input type="checkbox"/> Female	
<input type="checkbox"/> Non-binary/Prefer not to disclose (X)		<input type="checkbox"/> Unknown	

Part 3 - COVID-19 Risk Factors	Action Required	
<input type="checkbox"/> Direction has been given for the patient to remain on Contact and Droplet Precautions, Modified Respiratory Precautions, self-isolation or quarantine.	Defer appointment/procedure if possible and advise patient to call 811 (<i>as needed</i>) for quarantine/isolation instructions OR If appointment/procedure cannot be deferred, implement Modified Respiratory Precautions	
Assessed by	Date (<i>dd-Mon-yyyy</i>)	Time (<i>hh:mm</i>)