Alberta Health Services

Client Admission/Discharge/Transfer Questionnaire

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)	

This screener is to be completed for all clients prior to admission/ discharge/transfer to a designated living option *(DSL and LTC)* and should be **completed as close to admission/discharge/ transfer as reasonably possible.**

If the patient has any of the **BOLDED symptoms** ***(fever, cough, shortness of breath/difficulty breathing, runny nose, or sore throat)*** they are required to isolate for 10 days as per CMOH Order 05-2020 unless they receive a negative COVID-19 test and their symptoms have resolved.

If a resident answers YES to any of the questions 1-4, the individual must immediately:

- Be given a procedure/surgical mask
- Initiate isolation with contact and droplet precautions
- Notify health care provider/supervisor/LPN/RN to consider management and testing.

A "YES" to questions 1-4 does not exclude the individual from admission/transfer/discharge.

Decisions about safety precautions and isolation/quarantine requirements upon admission will be risk-based *(as per CMOH Order 32-2020 and in conjunction with a point-of-care risk assessment)*. Designated family/support persons should be aware of the risk tolerance assessment and site visitation restrictions. For concerns or questions, reach out to the accountable leader, zone MOH or designate.

1. Do you have any of the following symptoms *(Place check marks ✓ in "Yes" or "No" boxes)*	Yes	No
Fever		
Cough		
Shortness of Breath / Difficulty Breathing		
Runny Nose		
Sore throat		
Chills		
Painful / difficulty swallowing		
Hoarse voice		
Nasal congestion / stuffy nose		
Feeling unwell / fatigued / severe exhaustion		
Nausea / vomiting / diarrhea		
Unexplained loss of appetite		
Loss of sense of taste or smell		
Muscle / Joint aches		
Headache		
Conjunctivitis *(commonly known as pink eye)*		
Sneezing		
Altered Mental Status		
2. Have you travelled outside of Canada in the last 14 days ?		
3. Have you had close contact with a confirmed case of COVID-19 in the last 14 days? *(Face to face contact within 2 metres. A health care worker in an occupation setting wearing the recommended PPE is not considered to be a close contact.)*		
4. Have you had close contact with an individual who has any one of the first 5 **BOLDED** symptoms on this list: **fever, cough, shortness of breath/difficulty breathing, runny nose or sore throat - AND** who is a close contact of a confirmed case of COVID-19 in the last 14 days?		
5. Have you participated in an activity that would change your current risk level (*low, medium, high*)? Assess your personal risk of unknown exposure based on your last two weeks of activity *(refer to Risk of Unknown Exposure Checklist Form 21704)*		

Completed By	Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Additional notes