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			

Post COVID-19 Patient in Continuing Care Screening

This screening will be kept on your patient chart. If you respond "YES" **to questions 3 or 4**, notify your case manager or most responsible health care provider **to ensure that any additional care needs are assessed**.

1. Have you ever received a lab confirmed, positive test result for COVID-19?

   ☐ Yes
   ☐ No ▶ If no is checked, **STOP HERE**. Assessment is complete, and no further information is required.

Comments

2. Following your COVID-19 illness, have you ever been told that you had Post Intensive Care Syndrome (PICS), Post Viral Fatigue Syndrome (PVFS), Permanent Organ Damage (POD) or Long Term COVID Syndrome (LTCS)?

   ☐ Yes
   ☐ No

Comments

3. Are you back to doing your usual activites? *(e.g., walking, self-care, work, school, hobbies; continuing care patients as per existing care plan)*

   ☐ Yes
   ☐ No ▶ If you answered no, what is preventing you from returning to those activities? *(comment below)*

Comments

4. Are you experiencing any new, worsening or ongoing symptoms since your COVID-19 illness?

   Indicate assessment of symptom by documenting:
   A *(absent)*, **PS** *(pre-existing same)*, **PW** *(pre-existing worse)*, **NS** *(new since COVID-19 stable/improving)*, **NW** *(new since COVID-19 worse)* in the box beside each symptom.

Respiratory Symptoms		**Psychological Symptoms**	
	Shortness of breath/difficulty breathing at rest		Depression *(e.g. recurring sadness, isolating oneself, frequent negative thoughts)*
	Shortness of breath/difficulty breathing with activity		Anxiety *(e.g. fear, worry)*
	Cough		

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Post COVID-19 Patient in Continuing Care Screening

4. Are you experiencing any new, worsening or ongoing symptoms since your COVID-19 illness? ***(continued)***

Indicate assessment of symptom by documenting:
A *(absent)*, **PS** *(pre-existing same)*, **PW** *(pre-existing worse)*, **NS** *(new since COVID-19 stable/improving)*, **NW** *(new since COVID-19 worse)* in the box beside each symptom.

	Cardiovascular Symptoms		**Neurological Symptoms**
	Chest pain at rest		Issues with concentration, thiking or memory *(e.g. brain fog)*
	Chest pain with activity		Headaches
	Palpitations		Difficulty hearing
	Dizziness or fainting		Ringing in the ears
	Gastrointestinal Symptoms		Pins and needles/numbness
	Nausea and/or vomiting		Difficulty hearing
	Senses of taste/smell been affected		Ringing in the ears
	Difficulty eating/drinking/swallowing *(e.g. choking, painful swallowing, coughing while eating/drinking)*		Pins and needles/numbness
	Eating less than usual for more than 1 week		**Musculoskeletal Symptoms**
	Lost/gained a significant amount of weight without trying *Include amount of Weight gain/loss, for loss indicate a negative number:* ______________________ *(kg)*		Pain/discomfort *(including muscle/joint pain)* Pain orientation *(e.g. right, anterior)* _______________ Pain location *(e.g. groin)* _________________________
	Difficulty with bowels *(e.g. diarrhea, constipation)*		
	Difficulty with bladder *(e.g. incontinence/leakage secondary to cough)*		Generalized muscle weakness
			Difficulty controlling the movement of body *(loss of coordination)*
			Difficulty walking *(sense of imbalance)*

	Other Symptoms
	Fever *(describe, e.g., in the evenings, with activity, unexplained, or unexplained fever that comes and goes)*
	Fatigue/low energy
	Difficulty sleeping
	Additional symptoms *(specify)* ____

Assessed by	Date *(dd-Mon-yyyy)*	Time