Renfrew County and District Health Unit
"Optimal Health for All in Renfrew County and District"

# COVID-19 (2019-nCoV) External Reporting Form

**Reporting Agency:** ○ Acute Care ○ Primary Care ○ VTAC ○ Long-Term/RH Care

| ***IPHIS Information for RCDHU Only*** | **IPHIS CASE ID:** | **IPHIS CLIENT ID:** |
|---|---|---|

| **REPORTING SOURCE** | | |
|---|---|---|
| Name: | Report Date (YY/MM/DD): | Time: |
| Agency: | Phone Number: | |
| Fax Number: | Cell Number: | |

| **CLIENT INFORMATION** | | |
|---|---|---|
| Last Name: | First Name: | Gender: |
| DOB (YY/MM/DD): | Health Card Number: | |
| Phone Number: | Cell Number: | |
| Address: | City: | Postal Code: |
| Name of Parent/Guardian (*if applicable*): | | |
| **Occupation:** | Place of Employment: | |
| Family Physician: | Phone Number: | Fax Number: |

**COMPLETE THE FOLLOWING SCREENING QUESTIONS**

| **COMMON SYMPTOMS OF COVID-19** | **ATYPICAL SYMPTOMS OF COVID-19** |
|---|---|
| YES ○ NO ○ Fever (greater than 37.8) | YES ○ NO ○ Unexplained fatigue/malaise/myalgias |
| YES ○ NO ○ New or Worsening Cough | YES ○ NO ○ Acute functional decline |
| YES ○ NO ○ Shortness of breath (dyspnea) | YES ○ NO ○ Exacerbation of chronic conditions |
| **OTHER SYMPTOMS OF COVID-19** | YES ○ NO ○ Chills |
| YES ○ NO ○ Sore throat | YES ○ NO ○ Headaches |
| YES ○ NO ○ Difficulty swallowing | YES ○ NO ○ Croup |
| YES ○ NO ○ New olfactory or taste disorder(s) | YES ○ NO ○ Conjunctivitis |
| YES ○ NO ○ Nausea/vomiting/diarrhea | YES ○ NO ○ Delirium (acutely altered mental status and inattention) |
| YES ○ NO ○ Abdominal pain | YES ○ NO ○ Unexplained or increase in falls |
| YES ○ NO ○ Runny nose or nasal congestion – *in absence of underlying reason such as seasonal allergies, post nasal drip, etc.* | YES ○ NO ○ Multisystem inflammatory vasculitis in children – *presentation may include persistent fever, abdominal pain, conjunctivitis, GI symptoms and rash* |

| **OTHER SIGNS OF COVID-19** |
|---|
| YES ○ NO ○ Clinical or radiological evidence of pneumonia |
| **ATYPICAL SIGNS OF COVID-19** |
| YES ○ NO ○ Unexplained tachycardia, including age specific tachycardia for children |
| YES ○ NO ○ Decrease in blood pressure |
| YES ○ NO ○ Unexplained hypoxia (even if mild i.e. $O_2$ sat <90%) |
| YES ○ NO ○ Lethargy, difficulty feeding in infants (if no other diagnosis) |

## SYMPTOM ONSET DATE:

**This is a two-page document, both pages must be completed and faxed to RCDHU.**

Client Name: _____

| ADDITIONAL SCREENING QUESTIONS |
|---|
| YES ○ NO ○ Over 70 |
| YES ○ NO ○ Travelled Outside of Canada in last 14 days? **Date of Return:** _____ |
| YES ○ NO ○ Close contact* with positive COVID-19 case? **Date of Last Exposure:** _____ |
| YES ○ NO ○ Close contact* with someone sick with new respiratory symptoms or who travelled outside of Canada in the last 14 days? |
| **COMPLETE THE FOLLOWING SECTION** |
| YES ○ NO ○ Self-isolation teaching completed |
| YES ○ NO ○ Patient tested for COVID-19 at your facility/office. Date of testing: _____ |
| YES ○ NO ○ COVID-19 testing booked for patient (i.e. patient pre-registered for drive-thru clinic testing or referral has been sent to Community Paramedics) |
| YES ○ NO ○ RCDHU to arrange for COVID-19 testing |
| **PRIORITIZED GROUPS** |
| ○ Healthcare Worker/Caregiver/Care Provider/First Responder<br>**Place of Employment:** _____ |
| ○ Persons Living in the Same Household of Healthcare Worker/Caregiver/Care Provider/First Responder |
| ○ Hospital Inpatient<br>**Hospital:** _____ **Date Admitted:** _____<br>**Discharge Date:** _____ **Swab Results:** _____ **Client Aware** ○ YES ○ NO |
| ○ Resident Living in Long Term Care or Retirement Home **Facility:** _____ |
| ○ Resident of Other Congregate Living Setting/Institution<br>**Facility:** _____ |
| ○ Person Working in Congregate Living Setting/Institution<br>**Facility:** _____ |
| ○ Child attending Childcare Facility or School<br>**Facility/School:** _____ |
| ○ Remote/Isolated/Rural/Indigenous Community |
| ○ Specific Priority Population |
| ○ Essential Worker<br>**Employer:**_____ |
| ○ Cross-Border Worker |
| ○ Underlying chronic conditions<br>**Specify:**_____ |

## PLEASE FAX COMPLETED REPORTING FORM 613-735-3067

*A close contact is defined as a person who provided care for the patient, including Health Care Workers, family members or other caregivers, or who had other similar close physical contact ***OR*** who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill. Prolonged exposure may be defined as lasting more than 15 minutes, however exposures of <15 minutes may still be considered high risk depending on the context of the contact/exposure (i.e. individual was coughed on or sneezed on).

Any Ontarian presenting with at least one symptom or sign from the list above should be considered for testing for Covid-19.