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| **Client Care Notes:**  **Follow-Up for Clients who are Self-Monitoring or Self-Isolating at Home or Temporary Location** | **Client Label:**  **CLIENT NAME (Last Name, First Name):**  **Age: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_**  **Isolation Address:** | |
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| **Date of Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Level of Isolation: Self-Monitoring/Self-Isolation (circle one)**  **Social Situation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Education Provided:** |

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| **Date of COVID-19 Swab (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_ Date Result Received: \_\_\_\_\_\_\_\_\_\_** |

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| **Date/Time**  **(14 Days of Isolation)** | **Communication Method: Telephone/ Visit** | **Provide if Available:** | | **Heart Rate per minute: 60-100 beats per minute\*** | **Breaths per Minute:**  **12-20 breaths per minute\*** | **YES/NO** | | | | | | | | | | | |
| **Temperature  (°C or °F)** | **Glucometer Value** | **Cough** | **Shortness of Breath** | **Feeling confused** | **Chest Pain** | **Fever (shakes or chills)** | **Fatigue and/or muscle aches** | **Lack of appetite** | **Sore throat** | **Available resources (food, medicine, etc.)** | **Transport available** | **Changes to Social Situation** | **Appropriate PPE Available** |
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| **If the client is experiencing worsening symptoms or chronic health conditions, the client needs to see a health care provider for a complete reassessment – as per your community process for suspected COVID-19 cases.**  **\*If the rate is outside of the indicated range, the client needs to see a health care provider** | | | | | | | | | | | | | | | | | |

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| **Date (Y/M/D) @**  **Time 00:00** | **PROGRESS NOTES** |
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**Has the client been referred to a nurse for reassessment? If so, please forward this record with the reason for referral indicated below.**

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| New or worse symptoms?  Red Flag Symptoms (Difficulty breathing, Fever, Cough) | Is the client having difficulty managing illness at home?  Is the client following infection control practices? |