



Community:			
Nurse:	Date/Time:		
Name of Caller:	Phone Number		
Callers Relationship to Client:			
Name of Client:	Client's Phone Number:		
Date of Birth:	Band Number:		
COVID-19 Screening (circle yes or no for each question)	Have you traveled outside of the community within the last 14 days? <i>Where:</i> _____	YES	NO
	Have you had close contact with a confirmed or probably case of COVID 19?	YES	NO
	Do you have a fever, feel feverish, or having the shakes or chills?	YES	NO
	Do you have a new or worsening cough?	YES	NO
	Do you have a sore throat, muscle aches, runny nose, sneezing, headache, diarrhea, loss of smell or feeling fatigue?	YES	NO
	Do you feel short of breath or have difficulties breathing?	YES	NO
	If YES to any of above questions, continue triaging the client and then follow the "Disposition Advice" on page 2. If NO to ALL questions, continue triaging and arrange to see client based on triage score.		
Chief Complaint:			
Is this a request for an acute or wellness appointment? Acute _____ Wellness _____ **See Triage Screening Flow			
<ul style="list-style-type: none"> • <u>ACUTE</u>: continue with triaging • <u>WELLNESS</u>(immunization, well baby etc.), and COVID screen negative: book in with CLEAN nurse, hold phone/video appointment or if not a core service defer appointment. • <u>WELLNESS</u>, and COVID screen positive: continue to page 2 to determine if patient can be managed at home or needs to come in. 			
History of Present Illness/Mechanism of Injury:			
Neuro: (alert and orientated? any loss of consciousness? Alcohol or drug use?)		Level of consciousness _____	
		Change in activity level? YES NO	
Respiratory: RED FLAGS: Any acute respiratory symptoms are a positive screen for Covid-19 (breathing normally or any increased work of breathing/respiratory distress?)		Roth Test _____seconds counted (have the patient take a deep breath and count from 1-30. If they take another breath before they reach 8 seconds, this is indicative of an oxygen saturation < 95% and is a red flag)	
Cardiac: (any cardiac history, chest pain, radiation, worrisome cardiac features)			
Abdominal: (pain, nausea and vomiting, bowels and bladder)			
Pain: (LOPQRST)			
Bleeding: (location, amount)		Intake: Output:	
Past Medical History: (including chronic diseases, surgical history prenatal history, immunization status, meds, allergies and drug sensitivities)		RED FLAGS: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Lung Disease <input type="checkbox"/> CKD <input type="checkbox"/> Heart Disease <input type="checkbox"/> HIV <input type="checkbox"/> on immune suppression (steroids/biologics) **If client is older than 60 years of age, has any of above – HIGH RISK of Severe illness or death from COVID-19	
CTAS Level:			
Plan: If COVID-19 screen is <u>negative</u> , document plan here. If COVID-19 screen <u>positive</u> , continue to page 2 (include any health teaching done and instructions for follow-up. Include appointment date and time if following up during business hours. If the client is trying self-treatment, what is the plan if the treatment does not work or the condition worsens?)			
Patient in Agreement with Plan: YES NO			
Nurses Signature and Designation:			



For Clients Screening Positive for COVID-19

Are clients able to be managed at home, or do they need to come to clinic?

Reminder that all CTAS 1, CTAS 2 or CTAS 3 clients; clients under the age of 5 or over the age of 65; clients with PICC Lines, injured clients under the age of 18, clients with PICC Lines **must be seen** when they call.

It is also recommended that children over the age of 5, prenatal and postnatal women, clients who have recently had surgery or have been discharged from hospital in the last 48 hours are seen in person.

Clients that have mild symptoms can be managed at home. Clients with any red flags, significant PMH, clinical concerns or more severe symptoms will need to be assessed in person by a nurse.

See "COVID 19 Nursing Station Management" and "COVID 19 Nursing Station Processes" for direction

Client Will Be Managed (circle): **AT HOME** **MUST COME TO CLINIC**

Clients Able To Be Managed At Home	Clients that Need to Come to Nursing Station
<input type="checkbox"/> Asymptomatic <ul style="list-style-type: none"> • Advise to self-monitor, follow physical/social distancing (self-isolation if indicated) <input type="checkbox"/> Mild symptoms of viral respiratory illness, no red flags. May be COVID-19 or other virus. <ul style="list-style-type: none"> • Advise symptomatic management (hydration, acetaminophen prn) • <u>self-isolation for patient and household contacts</u> - Review Self Isolation Checklist • May do test based on current protocol (advise client when/where) • Add to PHN daily monitoring list 	<input type="checkbox"/> Needs more assessment - bring patient to nursing station (if any suspicion of COVID-19, must use PPE and designated respiratory exam room) <ul style="list-style-type: none"> • Advise client to come to clinic, using the designated 'respiratory door' at a designated time. Time should be within the time frames indicated for the client's CTAS level. Appointment Time: _____. • Advise the client that they will be asked to wear a mask and perform hand hygiene when they arrive at the clinic. • Request that the client come alone or bring only 1 escort to the clinic. If an escort comes, advise the client that the escort will also be required to wear a mask. • The nurse receiving the patient at the respiratory door must be wearing droplet/contact PPE. Nurse will assess patient using Respiratory Illness Documentation Tool

Additional Notes:

Nurses Signature and Designation: _____

(Please place in Nursing Notes (strike out remaining lines on NN page currently in use))