northern health
the northern way of caring

All sites and facilities

COVID-19 Surgical Patient Assessment Form

Name: _____

PHN: _____

DOB: _____

Unit: _____

PATIENT LABEL

NURSE OR MEDICAL OFFICE ASSISTANT SCREEN:

Able to obtain patient history? ☐ Yes ☐ No If No, go to Physician Screen section

Does the patient have a risk factor for COVID-19 exposure? In the last 14 days has the patient:

Returned from travel outside of Canada?	☐ Yes ☐ No	When? Date: _____
Been in close contact with anyone diagnosed with lab confirmed COVID-19?	☐ Yes ☐ No	When? Date: _____
Lived or worked in a setting that is part of a COVID-19 outbreak?	☐ Yes ☐ No	When? Date: _____
Been advised to self-isolate or quarantine at home by public health?	☐ Yes ☐ No	When? Date: _____
Exposure/contact at home with someone else that has been advised by public health to self-isolate or quarantine, but hasn't been tested?	☐ Yes ☐ No	When? Date: _____

Does the patient have new onset COVID-19 like symptoms?

24 to 72 hours prior – Date/Time: _____			Day of surgery – Date/Time: _____		
Fever	☐ Yes	☐ No	Fever	☐ Yes	☐ No
Cough	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Nausea and/or vomiting	☐ Yes	☐ No	Nausea and/or vomiting	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Runny nose/nasal congestion	☐ Yes	☐ No	Runny nose/nasal congestion	☐ Yes	☐ No
Sore throat or painful swallowing	☐ Yes	☐ No	Sore throat or painful swallowing	☐ Yes	☐ No
Loss of sense of smell	☐ Yes	☐ No	Loss of sense of smell	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No	Loss of appetite	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Chills	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No	Muscle aches	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No

Screened by: **Signature:** **Screened by:** **Signature:**

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PHYSICIAN SCREEN:

COVID-19 NP test performed (previous 14 days)	☐ Yes ☐ No	Date: _____ Result: ☐ Negative ☐ Positive
COVID-19 NP test(s) performed (over 14 days)? Reason: _____	☐ Yes ☐ No	Date: _____ Result: ☐ Negative ☐ Positive
If test has not been performed, do you recommend testing patient?	☐ Yes ☐ No	Reason: _____
Unable to perform swab?	☐ Yes ☐ No	Reason: _____
Type of anesthesia to be used	☐ General	☐ Local/Regional

Screened by: **Signature:** **Date/Time:** _____

FINAL SURGICAL TEAM ASSESSMENT:

COVID-19 risk factor (travel, contact, outbreak)?	☐ Yes	☐ No	☐ Unknown	
COVID-19 like symptoms that cannot be explained by another medical or surgical diagnosis?	☐ Yes	☐ No	☐ Unknown	
COVID-19 test result? (14 days or under)	☐ Yes	☐ No	☐ Unknown	☐ N/A

Print name: _____ Signature: _____

Date completed: _____

PATIENT RISK CATEGORY TABLE:

COVID-19 Symptoms/Signs	COVID-19 Exposures/ Contacts	COVID -19 Test Results (if applicable)	Risk Category
NO	NO	NOT REQUIRED	GREEN
NO	NO	NEGATIVE	GREEN
NO	YES	NEGATIVE	GREEN
UNKNOWN	NO	NEGATIVE	GREEN
YES	NO	NEGATIVE	GREEN
YES	YES	NEGATIVE	GREEN
UNKNOWN	UNKNOWN	UNKNOWN/PENDING	YELLOW
NO	YES	UNKNOWN/PENDING	RED
YES	NO	UNKNOWN/PENDING	RED
YES	YES	UNKNOWN/PENDING	RED
-	-	**POSITIVE**	RED

PATIENT RISK CATEGORY (CIRCLE ONE):

GREEN	YELLOW	RED