COVID−19 PRIMARY ASSESSMENT CHART (Version 13. 2020MAY29)

Preferred Patient Contact #: _____ Alternate Contact #: _____

Email: _____

If referred: Swab regardless of surveillance swabbing criteria.
If self−referred: Must meet surveillance swabbing criteria or case definition to be swabbed.

If the self−referred patient or resident / client does **NOT** present with any surveillance swabbing criteria, they do **NOT** require a swab. For patients presenting with concern of COVID−19 / SARS−CoV−2 infection (check all boxes that apply):

Surveillance Swabbing Criteria

- ❑ **Shortness of breath**
- ❑ Measured temperature (at home or within clinical setting) of greater than 38.0° C (or fever like symptoms: chills or sweats)
- ❑ Runny nose / nasal congestion (new or worsening)
- ❑ Sore throat
- ❑ Cough (new or exacerbation of chronic cough)
- ❑ Headache (new or worsening)
- ❑ Hoarse voice (new or worsening)
- ❑ New onset muscle ache
- ❑ Diarrhea
- ❑ Malaise
- ❑ Loss of sense of smell or taste
- ❑ Sneezing (new or worsening)
- ❑ Red, purple or blueish lesions on feet, toes or fingers without clear cause in persons 19 years old or younger

If presents with shortness of breath or looks unwell, patient requires further assessment prior to swabbing as per COVID−19 Primary Assessment Chart, proceed to **page two** and complete further assessment.

If **NO** shortness of breath and looks well, swab patient without further assessment and check all that apply:

- ❑ Swab collected
- ❑ COVID−19 Patient Information Sheet reviewed with patient and given to patient.
- ❑ Patient released
- ❑ Additional documentation, if required, completed in nursing / progress notes.

Name of Assessor (Printed)	Signature of Assessor	Date (YYYY/MON/DD)	Time

COVID−19 PRIMARY ASSESSMENT CHART (Version 13. 2020MAY29)

If presents with shortness of breath or looks unwell, complete vital signs below.

Baseline Vital Signs (Note Adult and Pediatric Red Flag Values below):

Temperature: _____ °C HR: _____ bpm RR: _____ SpO_2: _____ on room air

BP (if available and only if contacting physician): _____/_____

Assess for Red Flags.

Adult and Pregnancy Red Flags
Adult and pediatric Red Flags require medical / nurse practitioner (NP) consultation. IWK: Contact on−call physician for assessment site. NSHA PACs / Continuing Care / VON / First Nations: Contact Primary Assessment Site Support (PASS) Physician (902−473−2220). NSHA Extended PAC: Contact on−site Physician / NP when available.
• **Adult:** Heart rate greater than 110 • **Pregnancy:** Heart rate greater than 120 or less than 50
• **Adult:** Respiration rate greater than 30 • **Pregnancy:** Respiration rate equal to or greater than 30 or less than 10
• Chest pain
• **Adult:** SpO_2 less than 92% on room air • **Pregnancy:** SpO_2 less than 94% on room air

Pediatric Red Flag Vitals (if greater than 10 years use adult values)			
Peds (age)	**HR bpm**	**Respiratory Rate**	**Red Flags All Ages**
0 − 1 month	Greater than 180	Greater than 60	• Lethargy or extreme irritability • Increased work of breathing • SpO_2 less than 96 % • Pallor or cyanosis
1 month − 1 year	Greater than 160	Greater than 60	
1 − 4 years	Greater than 145	Greater than 50	
4 − 10 years	Greater than 125	Greater than 30	

If patient presents with Red Flags, do not swab.

Contact IWK on−call physician, NSHA PASS physician, NSHA on−site physician / NP using SBAR for communication. If ordered, RN / RRT / PT to swab, educate, and release home or ensure transport as per local pathway or EHS if required.

Check all that apply:

❑ Swab collected

❑ COVID−19 Patient Information Sheet reviewed with patient and given to patient.

❑ Further assessment required. Appropriate Physician contacted and patient: ❑ Released ❑ Sent to ED

❑ No further assessment required. Patient released.

❑ Additional documentation, if required, completed in nursing / progress notes.

NSHA Extended PAC / Continuing Care / VON / First Nations: If patient presents with NO Red Flags, proceed to page three.

If patient presents with NO Red Flags, and there is NO extended PAC, swab patient and check all boxes that apply above.

Name of Assessor (Printed)	**Signature of Assessor**	**Date (YYYY/MON/DD)**	**Time**

COVID−19 PRIMARY ASSESSMENT CHART (Version 13. 2020MAY29)

For NSHA Extended PAC / Continuing Care / VON / First Nations ONLY

Yellow Flags for NSHA Extended PACs (ILI / Respiratory Clinics) / Continuing Care / VON / First Nations ONLY: Check all that apply below and if any clinical concerns, collaborate with the on−site physician / NP when available. DO NOT CALL PASS PHYSICIAN.	
Respiratory	**Ear, Nose, Throat (ENT)**
❑ Shortness of breath +/− red flags	❑ Progressive ear pain
❑ Productive cough with fever	❑ Progressive sinus pain
❑ Respiratory rate 20−30 in Adults	❑ Progressive throat pain
❑ Audible wheeze	❑ Progressive dental pain
Other	
❑ Physician referral from community for in person respiratory assessment (after meeting COVID case definition)	
❑ Additional symptoms (e.g., vomiting, diarrhea with signs of dehydration): _____	

If presents with Yellow Flags, swab patient and check all that apply:

- ❑ Swab collected
- ❑ **Continuing Care / VON / First Nations:** Instruct patient to **call 811 for advice on where to seek healthcare** for Yellow Flags **OR** if symptoms worsen, or do not improve.
- ❑ **Extended PAC:** Patient has been referred to the on−site physician / NP
- ❑ COVID−19 Patient Information Sheet reviewed with patient and given to patient.
- ❑ Additional documentation, if required, completed in nursing / progress notes.

Name of Assessor (Printed)	**Signature of Assessor**	**Date (YYYY/MON/DD)**	**Time**