Office Use Only

Sp02 BME _____

AFFIX LABEL HERE

Covid-19 Report and Support Form

Updated October 28, 2024

USAGE OF INFORMATION

The Report and Support form helps identify people who are at higher risk for severe illness and hospitalization from COVID-19, within the first 5-7 days of developing symptoms. The form is used to determine whether a person is eligible for and would benefit from COVID-19 medications. Those who meet initial criteria will receive a phone call from a member of Nova Scotia Health's COVID-19 Treatment Team for further assessment.

As COVID-19 medications do not benefit everyone, you will only receive a phone call if you are eligible.
This information is collected responsibly and confidentially to improve COVID-19 recovery rates and provide better access to medicine.

People who identify as Black or African Nova Scotian and First Nations are among those at higher risk for severe outcomes from COVID-19. Anti-Black racism, systemic racism, higher rates of chronic disease and too few culturally specific health care services compound this risk. We ask people from these communities to voluntarily self-identify so people can be considered for medication based on all relevant personal risk factors.

This form is recommended to be completed if you have booked a PCR test or had a positive rapid test. If you complete the form before PCR testing and test negative, your information will be deleted.

Please complete the form as accurately as possible.

PRIVACY NOTICE
The personal health information you voluntarily provide on this form is protected under the Personal Health Information Act (PHIA). The submitted information received through this form is subject to Nova Scotia Health Authority security and privacy policies.

The collected personal health information will only be used to determine if someone is eligible for and would benefit from COVID-19 medication, unless otherwise authorized by law or your express consent. Information collected will be reviewed and assessed by the Nova Scotia Health COVID-19 Treatment Team, after which the original collection be deleted in 10 days.

Any secondary use or disclosure without express consent is limited to use for quality and risk management purposes or to aggregate de-identified information.

Please complete the form as accurately as possible. You will not receive an email confirmation of this information. **You will only receive a phone call for further assessment if you are eligible. COVID-19 medications do not benefit everyone. Seek medical help if your symptoms get worse by calling 811 or 911.** For COVID-19 information please visit https://www.nshealth.ca/coronavirus

Please circle/check your response and/or fill in the lines.
The content will be submitted into the online Report & SupportForm by a Nova Scotia Health employee.

What language(s) do you prefer to be contacted in? _____

Your Phone Number_____

If you have a phone number that can receive text messages, please include the number here _____

Do You have COVID-19 Symptoms? Yes ☐ No ☐ Prefer not to answer ☐

If YES, what date did your symptoms start? _____
day/month/year

If YES, please circle all symptoms you are experiencing:

☐ Cough (New or worsening/exacerbation of chronic cough)	☐ Fever (Chills, Sweats)	☐ Shortness of Breath or Difficulty Breathing
☐ Loss or change of sense of smell or taste	☐ Sore Throat	☐ Runny Nose or Nasal Congestion and or sneezing
☐ Headache	☐ Extreme fatigue/tiredness	☐ Nausea, Diarrhea, or vomiting

Are you currently admitted to hospital? Yes ☐ No ☐ Prefer not to answer ☐

To help ensure all personal risk factors such as, disease among people who identify as Black or African Nova Scotian and First Nations are taken into consideration, we ask people from these communities voluntarily self-identify.

Do you identify yourself as First Nation? Yes ☐ No ☐ Prefer not to answer ☐

Do you live in a First Nation Community? Yes ☐ No ☐ Prefer not to answer ☐

Do you identify yourself as one of the following? Yes ☐ No, my identity is not listed ☐ Prefer not to answer ☐

☐ African Nova Scotian	☐ African	☐ African Canadian
☐ Black	☐ African Caribbean	☐ Mixed Ancestry

Do you (or the client you are completing this for) live in any of the following group settings - Group Home, Small Options Home, Long Term Care, Residential Care Facility, Private Nursing Home, Assisted Living Centre, Disability Support Program or Shelter/Transition House?

Yes ☐ No ☐ Prefer not to answer ☐ If yes, name of facility/center_____

While most people with COVID can manage their COVID at home, some people with COVID are more likely than others to develop severe illness. In some cases, early treatment may reduce this risk. Please answer the following questions to help us assess whether you may be eligible for early treatments. Answering yes to these questions does not mean you necessarily need additional treatment. You will only receive a phone call for further assessment if you are eligible. COVID-19 medications do not benefit everyone.

If eligible for medication, we need to know your height and weight. Please fill in this information:

How tall are you? ____ft _____inches What is your best guess of your current weight? _____lbs Prefer not to answer ☐

Please circle the best response

Do you have active cancer? Yes ☐ No ☐ Prefer not to answer ☐

Are you taking any medications that suppresses your immune system? Yes ☐ No ☐ Prefer not to answer ☐

Have you had an organ transplant? Yes ☐ No ☐ Prefer not to answer ☐

Have you had a stem cell transplant in the past year? Yes ☐ No ☐ Prefer not to answer ☐

Are you pregnant? Yes ☐ No ☐ Prefer not to answer ☐

Do you wish to identify any conditions that you have based on a diagnosis from a care provider?

☐ Check here if you have none of the above conditions based on a diagnosis from a care provider

Chronic Kidney Disease	Yes ☐	No ☐	Prefer not to answer ☐
Diabetes	Yes ☐	No ☐	Prefer not to answer ☐
Heart Disease (High blood pressure, Heart attack, Heart failure)	Yes ☐	No ☐	Prefer not to answer ☐
Chronic Lung disease (COPD, Mod-Severe Asthma,interstitial lung disease, Cystic Fibrosis, Pulmonary Hypertension)	Yes ☐	No ☐	Prefer not to answer ☐
Sickle cell disease	Yes ☐	No ☐	Prefer not to answer ☐
Neurodevelopmental disorders (Cerebral palsy, trisomy 21/Down syndrome)	Yes ☐	No ☐	Prefer not to answer ☐
Medical- related technology dependence (Tracheostomy, Gastrostomy, Positive Pressure Ventilation, CPAP machine)	Yes ☐	No ☐	Prefer not to answer ☐
Primary immunodeficiency	Yes ☐	No ☐	Prefer not to answer ☐

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