COVID 19 Testing Assessment Form- PCR Test

Patient Name:	Date of Assessment:
Health Card Number:	Time of Assessment:
Date of Birth:	Gender:
Patient Address:	
Patient Email:	
Family Physician:	Pt Phone Number:
Date of Flight:	Flight Time: AM/PM

Verbal patient/agent consent received for the assessment:

Received by:	Date:

(Print name and Signature)

Patient Assessment Questions:

1. Are you experiencing any of the following symptoms? ☐ YES ☐ NO	
☐ Fever ☐ New onset of cough ☐ Worsening chronic cough ☐ Shortness of breath ☐ Difficulty swallowing ☐ Sore throat ☐ Difficulty swallowing ☐ Runny nose or nasal congestion without other known cause	☐ Decrease or loss of taste or smell ☐ Chills ☐ Headache ☐ Fatigue/malaise muscle /aches ☐ Nausea/vomiting, diarrhea, abdominal pain ☐ Pink eye (conjunctivitis)

2. In the past 14 days, did you return from travel outside of Canada?	
☐ YES	☐ NO

3. In the past 14 days, have you been identified as a close contact of someone who is confirmed as having COVID-19? ☐ YES ☐ NO
A close contact person is defined as a person: ☐ Who provided care for the patient, including healthcare workers, family members or other caregivers, or ☐ Who had other similar close contact or ☐ Who lived with or otherwise had close, prolonged contact with a proabable or confirmed case while the case was ill.

4. Have you been advised to get tested for COVID-19 by your local public health unit due to exposure to a confirmed case or as a part of an outbreak investigation?	
☐ YES	☐ NO

5. Have you been advised to get tested for COVID-19 through an exposure notification through the COVID-19 app?	
☐ YES	☐ NO

6. Are you over the age of 70 and experiencing any of the following: delirium, unexplained or increased number of falls, acute functional decline, worsening chronic conditions?	
☐ YES	☐ NO

Select one that applies:	
☐ If patient answered 'YES' to ANY of the questions numbered 1-6	**Refer** to COVID-19 Assessment centre
☐ If patient answered 'NO' to questions 1-6	**Eligible** for testing out our clinic