



COVID-19 Pre-Procedure Assessment Form

Patient Label

Surgical

Ambulatory

Obstetrics

Pediatric

24-72 HOURS PRIOR TO PROCEDURE

Date/Time:

Able to obtain patient history? Yes No *If No, promptly notify physician*

RISK FACTORS FOR COVID-19 EXPOSURE In the last 14 days:

Has patient been in close contact with anyone diagnosed with lab confirmed COVID-19? No Yes When? Date: _____

Has patient lived or worked in a setting that is part of a COVID-19 outbreak? No Yes When? Date: _____

Has patient been advised to self-isolate or quarantine at home by public health? No Yes Contact info: _____

Has patient returned from travel outside of Canada or from an area within Canada that is experiencing a COVID-19 outbreak? No Yes Return date: _____
Travel location: _____

DOES THE PATIENT HAVE NEW ONSET, COVID-19 LIKE SYMPTOMS?

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Runny nose/nasal congestion | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of sense of smell | <input type="checkbox"/> Nausea and/or vomiting | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sore throat or painful swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Headache | | | |

If Yes to any Risk Factor or COVID-19 like symptoms questions, promptly notify the Physician or appropriate Clinic

Physician/Office notified?
 Yes No

Patient referred for testing?
 Yes No

Printed Name

Signature

Designation

DAY OF PROCEDURE

Date/Time:

Able to obtain patient history? Yes No *If No, promptly notify physician*

RISK FACTORS FOR COVID-19 EXPOSURE In the last 14 days:

Has patient been in close contact with anyone diagnosed with lab confirmed COVID-19? No Yes When? Date: _____

Has patient lived or worked in a setting that is part of a COVID-19 outbreak? No Yes When? Date: _____

Has patient been advised to self-isolate or quarantine at home by public health? No Yes Contact info: _____

Has patient returned from travel outside of Canada or from an area within Canada that is experiencing a COVID-19 outbreak? No Yes Return date: _____
Travel location: _____

DOES THE PATIENT HAVE NEW ONSET, COVID-19 LIKE SYMPTOMS?

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|--|--|---|---------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Runny nose/nasal congestion | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Muscle aches |
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| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sore throat or painful swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Headache | | | |

If Yes to any Risk Factor or COVID-19 like symptoms questions, promptly notify the OR or appropriate Clinic.

Physician/Office notified?
 Yes No

Patient referred for testing?
 Yes No

Printed Name

Signature

Designation

PHYSICIAN SCREEN

COVID-19 NP test performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
COVID-19 NP test performed on Caregiver/Household member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
If test has not been performed, do you recommend testing patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason: _____
Unable to perform swab?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reason: _____
Type of anesthesia to be used	<input type="checkbox"/> General	<input type="checkbox"/> Local/Regional	
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; margin-top: 10px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Printed Name Signature Designation </div>			

FINAL PROCEDURE TEAM ASSESSMENT

COVID-19 risk factor (travel, contact, outbreak)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
COVID-19 like symptoms that cannot be explained by another medical or surgical diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Are COVID-19 test results available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
If Caregiver/household member tested, are COVID-19 test results available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A

CONFIRM PATIENT RISK CATEGORY (Refer to table below)

GREEN

 YELLOW

 RED

Printed Name
Signature
Designation

PATIENT RISK CATEGORY TABLE

COVID-19 Symptoms/ Signs*	COVID-19 Exposures/ Contacts*	Testing Required	COVID -19 Test Results (if applicable)**	Risk Category	Proceed with Scheduled Procedure
NO	NO	NO	NOT REQUIRED	GREEN	YES
NO	NO	NO	NEGATIVE	GREEN	YES
NO	YES	YES	NEGATIVE	GREEN	YES
UNKNOWN	NO	YES	NEGATIVE	GREEN	YES
YES	NO	YES	NEGATIVE	GREEN	YES
YES	YES	YES	NEGATIVE	GREEN	YES
UNKNOWN	UNKNOWN	YES	UNKNOWN/PENDING	YELLOW	YES
NO	YES	YES	UNKNOWN/PENDING	RED	ONLY IF URGENT, EMERGENT
YES	NO	YES	UNKNOWN/PENDING	RED	ONLY IF URGENT, EMERGENT
YES	YES	YES	UNKNOWN/PENDING	RED	ONLY IF URGENT, EMERGENT
-	-		POSITIVE	RED	ONLY IF URGENT, EMERGENT
-	-		CRGV/HSILD POSITIVE	RED	ONLY IF URGENT, EMERGENT

*If a caregiver/household member is symptomatic or has risk factors, that household member should be tested as well.

**Interpret the negative test in terms of the clinical context. If there is a confirmed COVID-19 exposure within the household, and a strong clinical suspicion of COVID-19 despite negative testing, treat at RED.