





COVID – 19 Screening Tool
Outpatient/Same Day Surgery/Direct Admission

Date: _____ Time: _____

INITIAL ALL APPLICABLE BOXES

☐ In-person Screen ☐ Telephone Screen

Part A	Symptom assessment. Ask patient if they have each of the following symptoms:	YES	NO
<input type="checkbox"/> Sudden onset of NEW cough or CHANGE to existing cough? <input type="checkbox"/> Fever of 38°C or greater on arrival or by patient history? Note: over age 65 and under age 5, fever may not be present <input type="checkbox"/> Sore throat? <input type="checkbox"/> Shortness of breath and/or difficulty breathing? <input type="checkbox"/> Pediatric – sudden onset of any of the following: <input type="checkbox"/> Runny nose, cough, sneezing? <input type="checkbox"/> GI symptoms (under the age of 5)?	Exclude symptoms related to an underlying medical condition (e.g. SOB related to ascites) Describe _____ ANY “yes” answers = “YES”  ALL “no” answers = “NO”	<input type="checkbox"/>	<input type="checkbox"/>

Part B	Within the past 14 days has the patient had ANY of the following:	YES	NO
<input type="checkbox"/> Travel to BC, ON, QC, AB <u>or</u> outside Canada (including USA)? Where: _____ <input type="checkbox"/> Close (within 2 metres) or prolonged contact with confirmed or probable case of COVID-19 without proper PPE? <input type="checkbox"/> Travel outside of Saskatchewan to mass gathering over 25?	ANY “yes” answers = “YES”  ALL “no” answers = “NO”	<input type="checkbox"/>	<input type="checkbox"/>

Patient Answers	Part A	Part B	Action		ID
	NO	NO	Does not fit COVID-19 screening criteria	Proceed with procedure.	
	NO	YES		Postpone procedure – instruct they self-isolate. If unable to postpone procedure – follow department process.	
	YES	NO	Fits COVID-19 screening criteria	Postpone procedure. Provide patient with information for the Off Site Testing Centre.	
	YES	YES		Fax this form to local Assessment Centre. If unable to postpone procedure – follow department process.	

COVID-19 nasopharyngeal swab: ☐ N/A ☐ Not sent ☐ Sent on (Date): _____

Signature/Designation: _____

FAX TO RECEIVING UNIT OR OPERATING ROOM WITH CONSENT IF PATIENT FOR SURGERY