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?

☐ Fever	☐ Runny nose/nasal congestion	☐ Loss of appetite	☐ Muscle aches
☐ Cough	☐ Loss of sense of smell	☐ Nausea and/or vomiting	☐ Fatigue
☐ Shortness of breath	☐ Sore throat or painful swallowing	☐ Diarrhea	☐ Chills
☐ 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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☐ Cough	☐ Loss of sense of smell	☐ Nausea and/or vomiting	☐ Fatigue
☐ Shortness of breath	☐ Sore throat or painful swallowing	☐ Diarrhea	☐ Chills
☐ 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?	☐ Yes	☐ No	Date:_____ Result: ☐ Negative ☐ Positive
COVID-19 NP test performed on Caregiver/Household member?	☐ Yes	☐ No	Date:_____ Result: ☐ Negative ☐ Positive
If test has not been performed, do you recommend testing patient?	☐ Yes	☐ No	Reason:_____
Unable to perform swab?	☐ Yes	☐ No	Reason:_____
Type of anesthesia to be used	☐ General	☐ Local/Regional	

_____ Printed Name

_____ Signature

_____ Designation

FINAL PROCEDURE TEAM ASSESSMENT

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