RVH
Royal Victoria Regional Health Centre

COVID-19 Surgical Patient Screening

NAME: _____

DOB: _____ (DD/MM/YYYY)

HRN: _____

Mandatory Pre-operative COVID-19 test booking date, time and location: **Result: □ Negative □ Positive**

_____

NO SWAB *required for patients having cataract surgery/endoscopy/interventional pain procedure under sedation*

This screening is to be completed 5 days prior to the surgical date.

Does the patient have a risk factor for COVID-19 exposure? In the last 14 days has the patient:

Returned from travel outside of Canada?	□ Yes □ No	When? Date: _____
Been in close contact with anyone diagnosed with lab confirmed COVID-19 or anyone awaiting a test result?	□ Yes □ No	When? Date: _____
Been in close contact with anyone with COVID-19 symptoms?	□ Yes □ No	When? Date: _____
Been advised to self-isolate or quarantine by Public Health?	□ Yes □ No	Contact Info: _____
Lived/worked in a setting identified as a COVID-19 outbreak?	□ Yes □ No	When? Date: _____
Resident of LTC, retirement home or other congregate setting?	□ Yes □ No	

Does the patient have new onset COVID-19 like symptoms? Date/Time: _____ Initials: _____

Fever	□ Yes □ No	Nausea, vomiting, diarrhea, abdominal pain	□ Yes □ No
New or worsening cough	□ Yes □ No	Unexplained fatigue/malaise/sore muscles	□ Yes □ No
New or worsening shortness of breath	□ Yes □ No	Chills	□ Yes □ No
Sore throat or difficulty swallowing	□ Yes □ No	Headaches (new or unexplained)	□ Yes □ No
Runny nose or nasal congestion without other known cause	□ Yes □ No	Pink eye (conjunctivitis)	□ Yes □ No
Decrease or loss of sense of taste or smell	□ Yes □ No	If over 70: delirium, unexplained falls, acute functional decline, or worsening of a chronic disease	□ Yes □ No

Positive symptoms reported to:_____

Screened by: _____ Signature: _____

PSTC/Operating Room (Next Day Trauma List):

Does the patient have new onset COVID-19 like symptoms? Date/Time: _____ Initials: _____

Fever	□ Yes □ No	Nausea, vomiting, diarrhea, abdominal pain	□ Yes □ No
New or worsening cough	□ Yes □ No	Unexplained fatigue/malaise/sore muscles	□ Yes □ No
New or worsening shortness of breath	□ Yes □ No	Chills	□ Yes □ No
Sore throat or difficulty swallowing	□ Yes □ No	Headaches (new or unexplained)	□ Yes □ No
Runny nose or nasal congestion without other known cause	□ Yes □ No	Pink eye (conjunctivitis)	□ Yes □ No
Decrease or loss of sense of taste or smell	□ Yes □ No	If over 70: delirium, unexplained falls, acute functional decline, or worsening of a chronic disease	□ Yes □ No

Positive symptoms reported to:_____

Screened by: _____ Signature: _____

R.C19SPS

RVH
Royal Victoria Regional Health Centre

COVID-19 Surgical Patient Screening

NAME: _____

DOB: _____
(DD/MM/YYYY)

HRN: _____

SDC or After Hours Add-on Cases:

Does the patient have new onset COVID-19 like symptoms? Date/Time: _____ Initials: _____

Fever	□ Yes □ No	Nausea, vomiting, diarrhea, abdominal pain	□ Yes □ No
New or worsening cough	□ Yes □ No	Unexplained fatigue/malaise/sore muscles	□ Yes □ No
New or worsening shortness of breath	□ Yes □ No	Chills	□ Yes □ No
Sore throat or difficulty swallowing	□ Yes □ No	Headaches (new or unexplained)	□ Yes □ No
Runny nose or nasal congestion without other known cause	□ Yes □ No	Pink eye (conjunctivitis)	□ Yes □ No
Decrease or loss of sense of taste or smell	□ Yes □ No	If over 70: delirium, unexplained falls, acute functional decline, or worsening of a chronic disease	□ Yes □ No

Has a COVID-19 test been performed pre-operatively? □ Yes □ No Date: _____
Result: □ Negative □ Positive

Rapid COVID test ordered and swab collected? □ Yes □ No Result: □ Negative □ Positive
Rapid COVID test result received? □ Yes □ No Result: □ Negative □ Positive

Screened by: _____ Signature: _____

Surgical Team Patient Assessment:

COVID-19 like symptoms not explained by medical or surgical diagnosis? □ Yes □ No □ Unknown
Risk of COVID-19 exposure (travel, close contact, quarantine, outbreak, congregate setting) □ Yes □ No □ Unknown
COVID-19 test result? □ Negative □ Positive □ Unknown

Alert IPAC of any patient classified as Yellow or Red

COVID-19 Symptoms/ Signs	COVID-19 Exposures/ Contacts	COVID -19 Test (if applicable)	Risk Category	Comments
NO	NO	NEGATIVE	GREEN	
YES	NO	NEGATIVE	GREEN	see (1) below
NO	YES	NEGATIVE	GREEN	see (2) below
YES	YES	NEGATIVE	YELLOW	see (1,2) below
NO	NO	UNKNOWN	YELLOW	
YES	NO	UNKNOWN	YELLOW	see (1) below
NO	YES	UNKNOWN	YELLOW	see (2,3) below
UNKNOWN	UNKNOWN	UNKNOWN	YELLOW	
YES	YES	UNKNOWN	RED	
--	--	POSITIVE	RED	

Screened by: _____ **Signature:** _____

COVID-19 symptoms: fever, new or worsening cough, new or worsening shortness of breath
Other symptoms: sore throat, difficulty swallowing, new olfactory or taste disorder, nausea/vomiting/ diarrhea/abdominal pain, runny nose/congestion in absence of other cause
Atypical symptoms: unexplained fatigue/malaise, chills, headache, croup, conjunctivitis, and especially in elderly: delirium, unexplained/increased number of falls, acute functional decline, exacerbation of chronic conditions
(1) Consider type and severity of symptoms when assigning to risk category.
(2) Consider IPAC consultation regarding timing of exposure and/or testing date.
(3) Red if untested patient is from an outbreak facility or had exposure to confirmed COVID+ contact.