BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

COVID-19 SURGICAL PATIENT ASSESSMENT FORM

DOCUMENT TYPE: FORM

MRN#:
Name:
DOB:
Language:
PHN#:

NURSE OR MEDICAL OFFICE ASSISTANT SCREEN:

Able to obtain patient history? □ Yes □ No If No, got to Physician Screen section

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?	□ Yes □ No	When? Date: _____
Lived or worked in a setting that is part of a COVID-19 outbreak?	□ Yes □ No	When? Date: _____
Been advised to self-isolate or quarantine at home by public health?	□ Yes □ No	Contact info: _____
Been in close contact with a household member who is sick or has Covid-19 like symptoms?	□ Yes □ No	Symptoms: _____

Does the patient have new onset COVID-19 like symptoms in the last 14 days?

24 to 72 hours prior – Date/Time: _____		Day of surgery – Date/Time: _____	
Fever >38C	□ Yes □ No	Fever >38C	□ Yes □ No
Cough	□ Yes □ No	Cough	□ Yes □ No
Shortness of breath	□ Yes □ No	Shortness of breath	□ Yes □ No
Diarrhea	□ Yes □ No	Diarrhea	□ Yes □ No
Nausea and/or vomiting	□ Yes □ No	Nausea and/or vomiting	□ Yes □ No
Headache	□ Yes □ No	Headache	□ Yes □ No
Runny nose/nasal congestion	□ Yes □ No	Runny nose/nasal congestion Sore	□ Yes □ No
Sore throat or painful swallowing	□ Yes □ No	throat or painful swallowing Loss	□ Yes □ No
Loss of sense of smell	□ Yes □ No	of sense of smell	□ Yes □ No
Loss of appetite	□ Yes □ No	Loss of appetite	□ Yes □ No
Chills	□ Yes □ No	Chills	□ Yes □ No
Muscle aches	□ Yes □ No	Muscle aches	□ Yes □ No
Fatigue	□ Yes □ No	Fatigue	□ Yes □ No

Screened by: **Signature:** **Screened by:** **Signature:**

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PHYSICIAN SCREEN:

COVID-19 NP test performed	□ 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 □ N/A	Reason: _____
Type of anesthesia to be used	□ General	□ Local/Regional

Screened by: **Signature:** **Date/Time:** _____

FINAL SURGICAL 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	
COVID-19 test result?	□ Yes	□ No	□ Unknown	□ N/A

PATIENT RISK CATEGORY TABLE:

COVID-19 Symptoms/ Signs	COVID-19 Exposures/ Contacts	COVID -19 Test Results (if applicable)	Risk Category
NO	NO	NOT REQUIRED	GREEN
NO	NO	NEGATIVE	GREEN
NO	YES	NEGATIVE	GREEN
UNKNOWN	NO	NEGATIVE	GREEN
YES	NO	NEGATIVE	GREEN
YES	YES	NEGATIVE	GREEN
UNKNOWN	UNKNOWN	UNKNOWN/PENDING	YELLOW
NO	YES	UNKNOWN/PENDING	RED
YES	NO	UNKNOWN/PENDING	RED
YES	YES	UNKNOWN/PENDING	RED
-	-	**POSITIVE**	RED

PATIENT RISK CATEGORY (CIRCLE ONE):

GREEN	YELLOW	RED

Please reference program specific Protocols for Management of Surgical Patient

References

http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_IPCProtocolSurgicalProceduresAdult.pdf

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Version History

DATE	DOCUMENT NUMBER and TITLE	ACTION TAKEN
04-Aug-2020	C-06-06-60754 COVID-19 Surgical Patient Assessment Form	Adapted from BCCDC by Maternal Newborn Program; Approved by Professional Practice Director

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