



## Post COVID-19 Patient in Continuing Care Screening

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male		<input type="checkbox"/> Female	
<input type="checkbox"/> Non-binary/Prefer not to disclose (X)		<input type="checkbox"/> Unknown	

This screening will be kept on your patient chart. If you respond “YES” to questions 3 or 4, notify your case manager or most responsible health care provider **to ensure that any additional care needs are assessed.**

<p>1. Have you ever received a lab confirmed, positive test result for COVID-19?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No ► If no is checked, <b>STOP HERE</b>. Assessment is complete, and no further information is required.</p>	
Comments	
<p>2. Following your COVID-19 illness, have you ever been told that you had Post Intensive Care Syndrome (PICS), Post Viral Fatigue Syndrome (PVFS), Permanent Organ Damage (POD) or Long Term COVID Syndrome (LTCS)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
Comments	
<p>3. Are you back to doing your usual activities? (e.g., walking, self-care, work, school, hobbies; continuing care patients as per existing care plan)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No ► If you answered no, what is preventing you from returning to those activities? (comment below)</p>	
Comments	
<p>4. Are you experiencing any new, worsening or ongoing symptoms since your COVID-19 illness?</p> <p>Indicate assessment of symptom by documenting:  <b>A</b> (absent), <b>PS</b> (pre-existing same), <b>PW</b> (pre-existing worse), <b>NS</b> (new since COVID-19 stable/improving), <b>NW</b> (new since COVID-19 worse) in the box beside each symptom.</p>	
Respiratory Symptoms	Psychological Symptoms
Shortness of breath/difficulty breathing at rest	Depression (e.g. recurring sadness, isolating oneself, frequent negative thoughts)
Shortness of breath/difficulty breathing with activity	
Cough	Anxiety (e.g. fear, worry)

## Post COVID-19 Patient in Continuing Care Screening

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

4. Are you experiencing any new, worsening or ongoing symptoms since your COVID-19 illness?  
**(continued)**

Indicate assessment of symptom by documenting:

**A** (*absent*), **PS** (*pre-existing same*), **PW** (*pre-existing worse*), **NS** (*new since COVID-19 stable/improving*), **NW** (*new since COVID-19 worse*) in the box beside each symptom.

Cardiovascular Symptoms		Neurological Symptoms	
	Chest pain at rest		Issues with concentration, thinking or memory <i>(e.g. brain fog)</i>
	Chest pain with activity		Headaches
	Palpitations		Difficulty hearing
	Dizziness or fainting		Ringing in the ears
Gastrointestinal Symptoms			Pins and needles/numbness
	Eating less than usual for more than 1 week	Musculoskeletal Symptoms	
	Lost/gained a significant amount of weight without trying		Pain/discomfort <i>(including muscle/joint pain)</i> Pain orientation <i>(e.g. right, anterior)</i> _____ Pain location <i>(e.g. groin)</i> _____
	<i>Include amount of Weight gain/loss, for loss indicate a negative number: _____ (kg)</i>		Generalized muscle weakness
	Difficulty with bowels <i>(e.g. diarrhea, constipation)</i>		Difficulty controlling the movement of body <i>(loss of coordination)</i>
	Difficulty with bladder <i>(e.g. incontinence/leakage secondary to cough)</i>		Difficulty walking <i>(sense of imbalance)</i>
Other Symptoms			
	Fever <i>(describe, e.g., in the evenings, with activity, unexplained, or unexplained fever that comes and goes)</i>		
	Fatigue/low energy		
	Difficulty sleeping		
	Additional symptoms <i>(specify)</i> _____ _____		
Assessed by		Date <i>(dd-Mon-yyyy)</i>	Time