COVID-19 Screening: For a person to enter an aged care facility

This form **must** be completed a maximum of 48 hours before proposed transfer or admission to an Aged Residential Care (ARC) facility.

# **Patient details**

|  |  |
| --- | --- |
| Full Name: | Click or tap here to enter text. |
| Address (or patient/person label): | Click or tap here to enter text. |
| NHI: | Click or tap here to enter text. |
| GP:  | Click or tap here to enter text. |
| Name of ARC facility: | Click or tap here to enter text. |
| What level of residential care is this person (NASC) assessed for? Has this recently changed?  | Click or tap here to enter text. |
| Has this person required close observation/specialling during their stay? Please provide details.  | Click or tap here to enter text. |

# **COVID-19 Contact Risk Assessment**

|  |  |
| --- | --- |
| Has the person, returned from overseas within in the last 14 days? | YES[ ]  NO[ ]  |
| Has the person been in close contact with a person with COVID-19 (probable or confirmed)? | YES[ ]  NO[ ]  |
| Has the person been in the same location during the last 14 days as someone who is either COVID-19 positive (confirmed or probable case) or is symptomatic and being tested for COVID-19, (excluding surveillance testing)? | YES[ ]  NO[ ]  |
| Has the person been isolated/quarantined in hospital or home environment for 14 days in relation to being either a close contact of a confirmed or probable case? If yes, please provide details.Click or tap here to enter text. | YES[ ]  NO[ ]  |

|  |  |  |
| --- | --- | --- |
| **YES** to **ANY** above indicates COVID-19 Contact assessment criteria **met** |  |  |
|  |  |  |
| **NO** to **ALL** indicates Contact assessment criteria **not met** |  |  |

# **COVID-19 Clinical Assessment**

Does the patient have any of the following symptoms that are **not** clearly explained by a non-COVID-19 condition? YES[ ]  NO[ ]

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| ***Common presenting symptoms (>20% of cases over 70):*** |
| [x]  Muscle pain | [ ]  Coryza (runny nose) | [ ]  Dyspnoea (shortness of breath) |
| [ ]  Fever  | [ ]  Sore throat | [ ]  New or worsening dry cough (not chronic) |
| [ ]  Weakness  | [ ]  Headache |
| ***Less common presenting symptoms (5-20% of cases over 70):*** |
| [ ]  Irritability, confusion or behaviour change  | [ ]  Nausea | [ ]  Diarrhoea  |
| [ ]  Joint pain  | [ ]  Vomiting  | [ ]  Chest pain  |
| ***Rare presenting symptoms (<5% of cases over 70):***  |
| [ ]  Abdominal pain | [ ]  Anosmia (loss of smell) | [ ]  Conjunctivitis |

Provide the latest clinical observations. Ensure status reflects relativity to the person’s normal status, eg, if they have chronic obstructive pulmonary disease etc.

|  |  |  |
| --- | --- | --- |
| Temperature (> 38.0°C or 1.1°C different from baseline)  | YES[ ]  NO[ ]  | Click or tap here to enter text. |
| Heart rate (>100)  | YES[ ]  NO[ ]  | Click or tap here to enter text. |
| Respiratory rate (>24)  | YES[ ]  NO[ ]  | Click or tap here to enter text. |
| SPO2 (<93% or 3% below normal baseline)  | YES[ ]  NO[ ]  | Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **YES** to **ANY** above indicates COVID-19 Clinical risk assessment criteria **met**  |  |  |
|  |  |  |
| **NO** to **ALL** above indicates Clinical risk assessment criteria **not met** |  |  |

# **Pathway**

|  |  |  |
| --- | --- | --- |
| Contact assessment criteria met Clinical assessment criteria met  | **HIGH** | Contact and Droplet IsolationSwab for COVID-19Contact Public Health who will advise the next actions (Do not discharge to ARC) |
| Contact assessment criteria metClinical assessment criteria not met | **MEDIUM** | Contact Public Health for advice - may need to Isolate for 14 days before transfer with a test at day 12  |
| Contact assessment criteria not met Clinical assessment criteria met | **LOW** | Low risk but swab for COVID-19Negative result before ARC entry |
| Contact assessment criteria not metClinical assessment criteria not met | **NIL** | Proceed to ARC |

Day of dx – phone handover and agreement to accept by ARC prior to the person leaving hospital, completed transfer documents in the discharge envelope including a copy of this screening form.

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| Signature, name and designation |  | Date and time of screening  |