Appendix 1: Severe Acute Respiratory Infection Care Report Form
COVID-19 Follow-Up

*The CD Unit will also accept a COVID-19 case report form from local PHU in place of Appendix 1

Client Demographics		**Date follow-up started:**
Last Name:		First Name:
Date of Birth: DD-MMM-YYYY	Age:	Gender: ☐ Male ☐ Female ☐ Other Specify:
Address:		Health Card Number:
City:	Postal Code:	Phone: Home: Cell: Work:
Email:		First Nations: ☐ Inuit ☐ Metis ☐
Occupation:		Health Care Worker: ☐ Yes ☐ No
Workplace/School:		Workplace/School Address:
Next of Kin:		Relationship / Phone: Home: Cell: Work:
Family Physician/HCP:		HCP Phone Number:

Reporting Information	Date reported to CD Unit: DD-MMM-YYYY
Name and designation of person completing form:	Phone Number:

Test Results				
Specimen Type (PCR, Serology, NAAT, Antigen)	Testing type (Laboratory or Point-of- Care)	Collection Date	Result	Date of Result:
		DD-MMM-YYYY		DD-MMM-YYYY
		DD-MMM-YYYY		DD-MMM-YYYY
		DD-MMM-YYYY		DD-MMM-YYYY

Case Classification

CHN must complete SARI Form and report to CD nurse and PHU who reports to Ministry. Ministry must report to PHAC within 24hrs of notification. See PH Management documents for details

Person Tested ☐ High index of suspicion for becoming a case (i.e. had high risk exposure – close contact, travel) ☐ Clinician has ordered COVID-testing; patient does not have high index of suspicion for becoming case	Date: DD-MMM-YYYY
Probable Case	Date: DD-MMM-YYYY
Confirmed Case	Date: DD-MMM-YYYY
Is case/contact part of an outbreak investigation? ☐ Yes ☐ No If yes, please indicate outbreak number:	

COVID-19 Vaccine History	
Number of vaccine doses received	☐None ☐1 dose ☐2 doses
Dates of vaccination, if applicable	1st dose: 2nd dose:

Client Name: _____

Vaccine product, if applicable	☐Pfizer ☐Moderna

Admitted to Hospital: ☐Yes ☐No			
Name of Hospital:		Room Number:	
Date admitted:	DD-MMM-YYYY	Date Discharged:	DD-MMM-YYYY
ICU:	☐Yes ☐No	Isolation precautions:	☐Yes ☐No
Oxygen Therapy:	☐Yes ☐No	Ventilator:	☐Yes ☐No

Signs and Symptoms (Symptoms to be monitored on daily clinical update form)				
☐No symptoms				
☐Abdominal pain	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Acute functional decline	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Acutely altered mental status	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Arthralgia/joint pain	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Anorexia/decreased appetite	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Chest pain	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Conjunctivitis	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Cough (new or worsening)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Cough (**Not** new or worsening)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Croup	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Delirium	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Diarrhea	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Dizziness	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Dysphagia (difficulty swallowing)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Ear ache	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Falls	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Fatigue	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Fever (≥37.8°C)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Fever (not recorded)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Chills	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Headache	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Hypotension	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Lethargy	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Lymph node swelling/pain	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Malaise	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Myalgia (muscle pain)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Nasal congestion (stuffy nose)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Nausea	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐New olfactory or taste disorder	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Palpitations	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Rash	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Rhinorrhea (runny nose)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Shortness of breath/ difficulty breathing	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Sneezing	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Sore throat	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Tachypnea (rapid breathing)	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Vomiting	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Unexplained hypoxia	☐Yes	☐No	**Onset date:**	**Recovery Date:**
☐Unexplained tachycardia	☐Yes	☐No	**Onset date:**	**Recovery Date:**

Client Name: _____

☐Other, please specify:	☐Yes ☐No **Onset date:**	**Recovery Date:**

Exposure - Travel			
In the past 14 days, did the patient travel (including within Canada)? ☐Yes ☐No ☐Unknown			
Province/ Country Visited	**Area in Province / Country**	**Hotel or Residence**	**Dates of Travel**

In the past 14 days, did the patient travel on a plane or other public transportation?

☐Yes ☐No ☐Unknown

Travel Type	**Carrier Name**	**Flight/ carrier #**	**Seat #**	**Departure (City, Country)**	**Arrival (City, Country)**	**Date of Travel**

Exposure – Human
In the past <u>14 days</u>, did the client come in close contact (cared for, lived for, spent significant time within closed quarters or had direct contact with respiratory secretions) **with:**
A confirmed case of COVID-19? ☐Yes ☐No ☐Unknown *case ID of contact:*
A probable case of COVID-19? ☐Yes ☐No ☐Unknown *case ID of contact:*
Close contact with a person with acute respiratory illness who has travelled outside of the province of Ontario or Canada? ☐Yes - *Please specify area of travel:* ☐No ☐Unknown

Medical Risk Factors	**None Identified:** ☐	
☐ Anemia or hemoglobinopathy	☐ Chronic liver disease:	☐ Obesity
☐ Asthma	☐ COPD	☐ Post-partum (≤6 weeks)
☐ Cancer (Specify):	☐ Diabetes	☐ Pregnant
☐ Cardiovascular condition	☐ Immunocompromised (Specify):	☐ Renal condition
☐ Chronic illness/underlying medical condition	☐ Neurologic disorder (Specify):	☐ Tuberculosis
☐ Unknown	☐ Other (specify):	

Client Name: _____

Behavioural Risk Factors	None Identified: ☐
☐ Alcohol abuse	**Resident of any of the following:** ☐ Correctional facility ☐ Adult developmental services residential site ☐ Adult or youth addiction site ☐ Children's residential site ☐ Homeless shelter ☐ Long-term care home or other chronic care facility ☐ Retirement home ☐ Violence against women or anti-human trafficking shelter ☐ Supportive housing facility ☐ Other congregate care setting
☐ Contact with animals	
☐ Homeless/under housed	
☐ Resident of nursing home or other chronic care facility	
☐ Travel outside province in the last 14 days (specify province or country):	
☐ Close contact with a case	☐ Injection drug use
☐ Nosocomial acquisition	☐ Smoker- Specify number of cigarettes smoked per day: __
☐ Visited a health care facility within the last 14 days	☐ Unknown

Occupational Risk Factors	None Identified: ☐
☐ Occupational - animal or animal product handler	☐ Occupational – addictions site
☐ Occupational – day care worker*	☐ Occupational – farm worker
☐ Occupational – first responder	☐ Occupational – health care worker*
☐ Occupational – laboratory worker	☐ Occupational – long term care or retirement residence*
☐ Occupational – school*	☐ Occupational – veterinarian
☐ Occupational – vulnerable populations* (homeless, shelter, ect)	

Socioeconomic Risk Factors		
Race Category: ☐ First Nation/Inuit ☐ Black ☐ East/South Asian ☐ Latino ☐ Middle Eastern ☐ White ☐ Another Race Category _____ ☐ Unknown ☐ Prefer not to answer	**Total Household Income:** ☐ $0 - $29,999 ☐ $30,000 - $49,999 ☐ $50,000 - $69,999 ☐ $70,000 - $99,999 ☐ $100,000 - $149, 999 ☐ $150,000 or more ☐ Prefer not to answer ☐ Do not know	• Household size: _____ • Childhood language (mother tongue): _____ • Official language most comfortable with: _____

Treatment Initiated ☐ Yes ☐ No							
Drug	Dose	Unit	Frequency	Route	Start Date:	End Date:	Comments
					DD-MMM-YYYY	DD-MMM-YYYY	
					DD-MMM-YYYY	DD-MMM-YYYY	
					DD-MMM-YYYY	DD-MMM-YYYY	

Complications	None Identified: ☐
☐ Acute respiratory distress syndrome	☐ Multisystem inflammatory syndrome
☐ Arrhythmia	☐ Pneumonia
☐ Delirium	☐ Renal failure
☐ Encephalitis	☐ Respiratory failure
☐ Heart failure	☐ Sepsis
☐ Guillain-Barre	☐ Seizures
☐ Liver failure	☐ Thromboembolic complications
☐ Meningismus / Nuchal rigidity	☐ Meningitis
☐ Unknown	☐ Other (specify):

Outcomes	
☐ Recovered, cleared from isolation	Date:
☐ Deceased Date:	Date:

Contact Tracing

Contact Tracing completed on *Appendix 5: Close Contact Tracing Worksheet Form*

☐Yes ☐No

Comments:

Progress Notes	
Date	Comments

Completed Date: DD-MMM-YYYY

CHN Investigator Name: _____

CHN Investigator Signature: _____

Progress Notes	
Date	Comments

Completed Date: DD-MMM-YYYY

CHN Investigator Name: ________________________

CHN Investigator Signature: ____________________