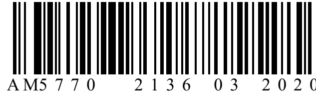
Eastern Health

Infection Control

COVID-19 Triage Screening Tool



Name ____________________

HCN ____________________

Date of Birth (DD/MONTH/YYYY) ____________________

1. Do you have **two or more** of the following symptoms (new or worsening):

- fever (or signs of a fever such as chills, sweats, muscle aches and lightheadedness) ☐ Yes ☐ No
- cough; ☐ Yes ☐ No
- headache; ☐ Yes ☐ No
- sore throat ☐ Yes ☐ No
- runny nose; ☐ Yes ☐ No
- painful swallowing; ☐ Yes ☐ No
- unexplained loss of appetite/diarrhea; ☐ Yes ☐ No
- loss of sense of smell or taste; ☐ Yes ☐ No
- experiencing small, red or purple spots (chilblain-like lesions) on feet and/or hands? ☐ Yes ☐ No

HAVE YOU:

2. Travelled outside Newfoundland and Labrador in the 14 days before onset of illness? ☐ Yes ☐ No

3. Been in close contact with a known or suspect case of COVID-19? ☐ Yes ☐ No

4. Been in close contact with a person with acute respiratory illness who has travelled outside of Newfoundland and Labrador within 14 days prior to their illness onset? ☐ Yes ☐ No

If yes to any of the above, place on contact/droplet precautions and notify Infection Control Practitioner.

Comments:

Name ____________________ Date (DD/MM/YYYY) ____________________

Signature ____________________