Remote Care Monitoring Project

Mamaway Wiidokdaadwin Indigenous Interprofessional Primary Care Team

Referral Form: Patient Self-Referral

COVID-19 Screening for In-person Visits

Last Name:

First Name:

Gender: *

Male **Female**

Address:

City:

Postal Code:

DOB: *

Day: **Month:** **Year:**

Health Card:

Preferred Tel:

Alternative Tel:

Cell:

Email:

Date of Symptoms Onset:

How would the patient like to receive notification to participate in the program?

○ **By Text** ○ **By Email**

What is your Vaccination Status?

☐ Double vaccine + booster
☐ Double vaccine
☐ Single dose vaccine
☐ Unvaccinated
☐ Pregnancy

Are you currently experiencing any of these Issues:

YES☐ NO☐ Severe Difficulty Breathing (Struggling to breathe or speaking in single words)

YES☐ NO☐ Severe Chest pain (Constant tightness or crushing Sensation)

YES☐ NO☐ Feeling Confused or unsure of where you are

YES☐ NO☐ Losing Consciousness

Do you have any of the following New or Worsening Symptoms or signs?

Symptoms should not be chronic or related to other known causes or conditions.

YES☐ NO☐ Fever or Chills

YES☐ NO☐ Difficulty breathing or shortness of breath

YES☐ NO☐ Cough

YES☐ NO☐ Sore throat, trouble swallowing

YES☐ NO☐ Runny nose/stuffy nose or nasal congestion

YES☐ NO☐ Decrease or loss of smell or taste

YES☐ NO☐ Nausea, vomiting, diarrhea, abdominal pain

YES☐ NO☐ Not feeling well, extreme tiredness, sore muscles

YES☐ NO☐ Headache

YES☐ NO☐ Joint pain

Other

In the last 10 days, has someone you live with:

YES☐ NO☐ Been sick with symptoms associated with covid-19?

YES☐ NO☐ Tested positive for Covid -19 (on a rapid antigen test or PCR test)?

Have you had close contract with a confirmed or probable case of Covid-19? YES☐ NO☐

Have you travelled outside of Canada in the past 14 days? YES☐ NO☐

Have you tested positive for covid -19 or are you awaiting test results? YES☐ NO☐

Primary Care Provider's Information:

Emergency Contact Information:

Last Name:

First Name:

Telephone:

Relationship:

Other Relevant History

Please include baseline Oxygen Saturation Levels:

Other Relevant History:

Lists Medications AND/OR additional instructions or notes:

Please fax this referral to: Fax: 855-941-2529