Ontario Society of Occupational Therapists

# Supporting Your Professional Practice

## Sample COVID-19 Screening and Risk Identification Tool
## For use in Ontario's auto insurance sector
## June, 2020

As of May 26, 2020, Occupational Therapists are working under an amended Ministry of Health Directive #2 which recommends that healthcare providers, including OTs, do as much work virtually as possible, leaving in-person interactions for activities which cannot effectively be done virtually. Refer to the College of Occupational Therapists of Ontario Information on COVID-19 website for updates.

This sample screening and risk identification tool can be used with claimants (prior to an in-person session) to help identify and agree upon a suitable plan to reduce the risks of an in-person intervention. This is not to be used as a consent form or to replace any part of the consent process. Feel free to modify this form to suit your needs. The screen should be carried out as close as possible to the actual OT intervention to determine if an in-person session is possible. This does not replace the point of contact screen (in-person screen).

Client Name: ______________________________

Age: ______________________________

Date of Screening: ______________________________

Proposed date for assessment/treatment: ______________________________

| **COVID-19 Screening:** | | |
|---|---|---|
| Have you been in close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days? | Yes | No |
| Have you had a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19? | Yes | No |
| If yes, when was your first negative COVID-19 test (date)? | | |
| Does anyone in your family/home have COVID-19? | Yes | No |
| If yes, when was their first negative COVID-19 test (date)? | | |
| Have you had a COVID test and tested Negative on (date)? | Yes | No |
| COVID Screen Results Unknown: | Yes | No |
| Do you have any of the following symptoms: (Check all that apply) | | |

| | | |
|---|---|---|
| Fever | Yes | No |
| New onset of cough | Yes | No |

| Symptom | | |
|---|---|---|
| Worsening chronic cough | Yes | No |
| Shortness of breath | Yes | No |
| Difficulty breathing | Yes | No |
| Sore throat | Yes | No |
| Difficulty swallowing | Yes | No |
| Decrease or loss of sense of taste or smell | Yes | No |
| Chills | Yes | No |
| Headaches | Yes | No |
| Unexplained fatigue/malaise/muscle aches (myalgias) | Yes | No |
| Nausea/vomiting, diarrhea, abdominal pain | Yes | No |
| Pink eye (conjunctivitis) | Yes | No |
| Runny nose/nasal congestion without other known cause | Yes | No |

| Question | | |
|---|---|---|
| If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? | Yes | No |

| **Discussion points to support determining risk:** |
|---|
| Have you been diagnosed with any of the following? (N.B. comorbidities may increase susceptibility to, or severity of symptoms – consider if they impact your decision-making process) |

| Condition | | |
|---|---|---|
| Respiratory condition (e.g. COPD) | Yes | No |
| Hypertension | Yes | No |
| Diabetes | Yes | No |
| Cardiac Condition | Yes | No |
| Immunocompromised | Yes | No |
| Other | Yes | No |

| Question | | |
|---|---|---|
| Is anyone in your family working outside the home? | Yes | No |
| If yes, what do they do? | | |

| Question | | |
|---|---|---|
| While the therapist is in your home, are you willing to wear a mask? | Yes | No |
| If yes, do you have your own mask? | Yes | No |
| Do you have children or other dependents who will be in the home at the time of the assessment/treatment? | Yes | No |
| If yes, can physical distancing be maintained during the assessment/ treatment? | Yes | No |
| Will an Interpreter be required? | Yes | No |
| If yes, what language is required?<br>*Note: Interpreters will be asked to wear a mask and/or face shield. | | |
| Do you require any person to assist you during the assessment/ treatment? | Yes | No |
| If yes, is that individual willing to wear a mask? | Yes | No |

**Agreement**

If an in-person examination or treatment session is needed, you may wish to bring this form with you to review and sign with the claimant.

I understand the risks during COVID-19 and I agree to proceed with an in-person occupational therapy examination OR treatment on (date) ____________________. I understand that myself, family members who plan to attend with me (if applicable), and the therapist agree to wear the following:

| | Client | | Therapist | |
|---|---|---|---|---|
| Mask | Yes | No | Yes | No |
| Face Shield/eye protection | Yes | No | Yes | No |
| Gloves | Yes | No | Yes | No |
| Gown | Yes | No | Yes | No |

| | |
|---|---|
| Signature (Claimant) | Date |
| Print Name (Claimant) | |
| Occupational Therapist Signature | Date |