northern health
the northern way of caring

COVID-19 Case Interview Form

When form completed please send to Northern Health via FAX to the CD Hub at 250-645-7995 or via Kiteworks within 48 hours.

Introduction, results, and demographics

Name:		Alternate name(s):
Mature minor: ☐ Consent to complete interview ☐ Consent for parent/guardian to complete interview		
Who is providing this information?		Relationship to case:
DOB:	PHN:	Phone:
Parent/guardian (if applicable):		Primary care provider:
Email address:		

Who to do ADM? ☐ CHN to do ADM ☐ Virtual clinic ☐ Family physician

☐ Case received their results ☐ Confirm case diagnosis ☐ Epi-linked case
☐ There are other members in household who have tested positive and are waiting for first phone call

Home address (include community):

Planned isolation location: ☐ Home ☐ Other, please specify address and community

☐ Health and Vaccination Status

Fully immunized with asymptomatic and/or mild to moderate illness
☐ Yes 5 day isolation period-if meet criteria to be eligible to end isolation on day 5, then self monitor for 5 days ☐ No [10 day isolation]
Vaccine Status: Number of doses received ☐ none ☐ one Date_____ ☐ two Date _____ ☐ booster Date _____
Number of days since last dose: _____
Moderately immunocompromised and/or severe or critical COVID-19 illness: ☐ Yes
☐ Fully vaccinated - 10 day isolation period ☐ Not fully vaccinated - 20 day isolation period ☐ Not sure
☐ Pregnant Weeks gestation:

Symptoms

Symptoms of COVID-19: ☐ Yes ☐ No	Date symptoms started:

Acquisition period (14 days prior to symptom onset or test date): _____
Infectious period (2 days prior to symptom onset or test date until end of isolation period):

Sources of exposure

Client informed of exposure to COVID-19? ☐ No ☐ Yes, complete all the questions about exposure currently listed.

Who notified you of exposure?
☐ Person who tested positive: _____ (Name) ☐ Public health ☐ Health center
☐ Facility/organization: _____ (Name) ☐ Other: _____

Date of notification:	Last date of exposure: OR Ongoing contact: ☐ Yes ☐ No

Where did exposure occur?

☐ Household	☐ First Nations community	☐ Health care facility	☐ Industry work camp
☐ Other congregate housing facility	☐ School	☐ Childcare setting	☐ Workplace
☐ Industrial site	☐ Courthouse	☐ Don't know	☐ Other

Name of location where exposure occurred:	
Address:	
Community:	

First Nations Health Authority
Health through wellness

Sources of exposure *(continued)*

Where does the client think they got their COVID-19 infection? (all relevant details e.g. facility, address, community, dates, times, and/or other details)

Factors to consider

Factors that may have contributed to a transmission risk: _____

Is there a risk for the case to continue to expose any settings during their infectious period (unable to self-isolate)

☐ Yes ☐ No

Transmission settings

☐ **Health care worker** Community: _____

Dates/times worked: _____

Role: _____ Name/address of facility: _____

Vaccination 1 date: _____ and Vaccination 2 date: _____ Booster date: _____

Supervisor: _____ ☐ Consent to contact

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

☐ **First Responder** Community: _____

Dates/times worked: _____ Name of facility: _____

Address: _____

Role: _____

Supervisor: _____ ☐ Consent to contact

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

☐ **Health care facility (hospital/inpatient)** Community: _____

Dates/times: _____ Ward/Unit/Dept: _____

Role: _____ Name/address of facility: _____

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

☐ **Services in the home (home care/support)** Community: _____

Dates/times: _____ Name of service: _____

Role of provider: _____

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

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Transmission settings *(continued)*

☐ **Congregate housing/residential setting** Community: _____

☐ Long-term care facility ☐ Residential care facility
☐ Assisted or independent living facility ☐ Seniors residence ☐ Group home
☐ Correctional facility ☐ Residential treatment facility ☐ Transition house ☐ Shelter
☐ Couch surfing ☐ Living on the street

Dates/times: _____

Role: _____ Name/address of facility: _____

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

☐ **Industry work camp** Community: _____

Name of camp: _____

Location: _____

Who operates camp: _____ ☐ Attached to single project

COVID-19 coordinator/medical service provider name: _____ ☐ Consent to contact

Phone number: _____ Date of arrival: _____

Form of Travel: _____ Date of departure: _____

PPE measures used in setting: ☐ 2 meters distance ☐ physical barriers ☐ PPE used ☐ handwashing

Contacts (name): _____

Comments: _____

Contact tracing

Name	Phone number
Exposure location	Last date of exposure (or ongoing contact):
DOB	Home/community
Additional information	
Name	Phone number
Exposure location	Last date of exposure (or ongoing contact):
DOB	Home/community
Additional information	
Name	Phone number
Exposure location	Last date of exposure (or ongoing contact):
DOB	Home/community
Additional information	

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☐ Isolation supports:

Do other people live or stay in household? ☐ Yes ☐ No
Is client able to self-isolate and remain separate from other household members until end of isolation date? ☐ Yes ☐ No
Is client able to stay in household until end of isolation period? ☐ Yes ☐ No
Have you notified anyone that you have spent time with of your COVID-19 diagnosis? ☐ Yes ☐ No

☐ **Substance Use:**

Does client need support to access substances or prescription medications to prevent withdrawal? ☐ Yes ☐ No

Does client need access to safe supply or treatment while isolating ☐ Yes ☐ No

☐ **Prescriptions:**

Is the client able to fill any medication prescriptions through their primary care provider or by requesting an emergency supply during the isolation period? ☐ Yes ☐ No Specify: _____

☐ **Provided isolation instructions**

First Nations community/Indigenous persons

☐ Does the client live or stay in First Nations community?

Community Name: _____

Does the client dentify as an Indigenous person? ☐ Yes ☐ No If yes: ☐ First Nations ☐ Métis ☐ Inuit

☐ Registered with a First Nations band (name): _____

☐ Consent to share personal information with FNHA for purpose of additional supports

☐ Consent to share personal information with MNBC for purpose of additional supports

Was First Nations Referral for supports made? ☐ Yes ☐ No

Completed by (name and position): _____ Date: _____