BCRenal
Provincial Health Services Authority

Hemodialysis Patient Screening Questionnaire for Influenza-like Illness/COVID-19

▶ Please complete for every patient at every HD visit prior to the patient's entry into the HD unit.

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

Date of Birth (MM/DD/YYYY): _____

PHN: _____

Date: _____

On arrival, ask the patient each of the following 5 questions:

Does the patient:	Yes	No	Staff Initial
1. Have a temperature ≥37.5 or self-reported fever?			
2. Have a sore throat?			
3. Have a new or worsening cough (compared to their baseline)?			
4. Have difficulty breathing/shortness of breath (compared to their baseline)?			
5. Report close contact with a known or suspected COVID-19 positive person within the past 14 days?			

During the screening process, did the patient mention any other symptoms (check all that apply):

Myalgia	☐	Abdominal pain	☐
Malaise	☐	Diarrhea	☐
Headache	☐	Nausea/vomiting	☐
Sneezing	☐	Loss of taste or smell	☐
Runny nose/nasal congestion	☐		

▶ If the answer to at least 1 question above is "yes", please place the form in the designated box.