COVID-19 POSITIVE

Case Summary

QAIHC
Queensland Aboriginal and Islander Health Council

Date of assessment:	**Assessed by:**

CASE Name:	
DOB:	**Sex:** ❑ Female ❑ Male ❑ Other
Indigenous Status: ❑ Aboriginal ❑ Torres Strait Islander ❑ Aboriginal and Torres Strait Islander ❑ Neither	
Usual address:	
Phone:	**Email:**
Medicare Number:	**GP Name:**
Occupation:	**Last date of work:**
Vaccination status: ❑ Unvaccinated ❑ One dose ❑ Two doses ❑ Booster dose	
Date of positive RAT if had one:	**Date of positive PCR test:**
Date of first symptoms:	
Do you know where/from whom you may have contracted COVID-19? Please provide details:	

Household close contacts for two days prior to being unwell or the positive test (names, age, phone); defined by vaccination status, exposure to case and defined exposure site	1. 2. 3. 4. 5. 6. 7. 8. 9. 10.
Other close contacts more than 4 hours face-to-face contact (names, age, phone, place of contact)	1. 2. 3. 4. 5.
Quarantine/isolation location:	

Infectious Period:	**Time in community:**

Has the person been at a high-risk setting whilst infectious?

❑ Healthcare facility ❑ Aged or residential care facility ❑ Disability housing or group home
❑ Childcare facility ❑ Educational/boarding facility ❑ Correctional facility/detention

SYMPTOMS			**Have they had a chest X-ray since sick?**	❑ Yes	❑ No
What day did their symptoms start?			**What day was their COVID test?**		
What symptoms do they have at the moment?					
Chills/ sweats	❑ Yes	❑ No	Not eating well	❑ Yes	❑ No
Fever >38 degrees	❑ Yes	❑ No	Vomiting	❑ Yes	❑ No
Fatigue/ weakness	❑ Yes	❑ No	Diarrhoea	❑ Yes	❑ No
Headache	❑ Yes	❑ No	No symptoms	❑ Yes	❑ No
Symptoms of a cold (runny nose, sore throat, muscle aches)				❑ Yes	❑ No
CONCERNING SYMPTOMS					
Chest pain	❑ Yes	❑ No	Persistent cough	❑ Yes	❑ No
Dizziness upon standing	❑ Yes	❑ No	No oral intake	❑ Yes	❑ No
Rapid breathing (<30 or >=30 breaths per minute) /difficulty breathing / shortness of breath.				❑ Yes	❑ No
HIGHER RISK CHARACTERISTICS					
Age >50	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No	Organ transplant	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Recent stroke	❑ Yes	❑ No
Lung disease	❑ Yes	❑ No	Obesity	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Weakened immune system	❑ Yes	❑ No
Taking prednisolone, methotrexate, hydroxychloroquine or any medication that they regularly receive through a drip				❑ Yes	❑ No
OTHER MEDICAL HISTORY			Do they look well?	❑ Yes	❑ No
Do they have other medical problems?					
What tablets do they take?					
Are they pregnant?	❑ Yes	❑ No	If yes, how many weeks?		
SOCIAL HISTORY:					
Are they safe at home?	❑ Yes	❑ No	**Is their mental health OK?**	❑ Yes	❑ No

RESULT OF ASSESSMENT:		**OK to stay at home?**	❑ Yes ❑ No
Discuss with Doctor			