COVID-19

help us prevent spread

READ THIS CAREFULLY

CSC is currently taking measures to ensure your safety, the safety of our staff and offenders and limit the risk of infection. To help us prevent the spread of COVID-19, we ask you to read this carefully and answer the questions below. Please act accordingly following the screening questions.

1 Are you **feeling sick**? (Examples include a **new cough, headache, weakness, fever, difficulty breathing, loss of smell** or **taste, loss of appetite, chills**, etc.)

☐ Yes ☐ No

If yes then:

Return home and **contact public health**. You may be required to self-isolate.

Contact your manager.

If no then:

2 Have you **travelled outside Canada** in the past 14 days?

☐ Yes ☐ No

3 Did you **provide care** or have **close contact** with a person **with COVID-19** (probable or confirmed) while they were ill and you **did not** have appropriate PPE?

☐ Yes ☐ No

If yes to one or more then:

Do not enter the building. Return home.

Contact your manager.

Reduce your risk of infection by:

- frequently washing your hands with soap and water or hand sanitizer for at least 20 seconds
- coughing or sneezing into your arm or tissue
- avoiding touching your eyes, nose or mouth with unwashed hands
- avoiding close contact with people who are sick to avoid spreading the illness to others

For more information on COVID-19, please visit: **Canada.ca/coronavirus**

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PROTECTED **B** ONCE COMPLETED

PERSONAL INFORMATION BANK

COVID-19 SCREENING FORM FOR USE BY HEALTHCARE To be completed: • As part of the intake process with form 1244 • When an asymptomatic inmate develops symptoms • Upon return from an outside hospital • Prior to transfer to another institution • Prior to release to the community		**SEND FORM TO HEALTH CARE** FPS Number (if possible): Family name: Given name(s): Date of birth:
Region:	Institution:	Date Completed:

A. Is the person presenting with:		
□Yes □No	Fever (temperature of 38°C or greater)?	Date of symptom onset (YYYY/MM/DD)
□Yes □No	Any respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, sore throat, difficulty swallowing)? Please specify: _____	Date of symptom onset (YYYY/MM/DD)
□Yes □No	Any atypical symptoms (including but not limited to chills, muscle aches, diarrhea, malaise, headache)? Please specify: _____	Date of symptom onset (YYYY/MM/DD)
B. In the 14 days before onset of illness, has the patient:		
□Yes □No	Had **close** contact with a confirmed case or case under investigation of COVID-19?	Date of contact (YYYY/MM/DD)
□Yes □No	Had **close** contact with a symptomatic individual?	Date of contact (YYYY/MM/DD)

□ Yes to any one of A or B	**□ No to all the above questions**
• Refer to the relevant algorithm • Provide treatment as required	• Refer to the relevant algorithm • Monitor for symptoms

Personal information will be protected under the provision of the *Privacy Act*. The information is stored in the Standard Bank # 060.
Original: Copy Offender Health file

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PROTECTED **B** ONCE COMPLETED

FOR INMATES

INMATES COVID-19 BRIEF SCREENING for use by Operations To be completed: • For all new WOC and inmates returning to federal custody • For inmates returning from an outside hospital outside of Health Services business hours		**SEND FORM TO HEALTH CARE** FPS Number (if possible): Family name: Given name(s):
Region:	Institution:	Date Completed:

1. In terms of how you are feeling today:	
□ Yes □ No	Do you feel like you have a fever?
□ Yes □ No	Are you experiencing any respiratory symptoms (such as cough, shortness of breath, runny nose, sneezing, nasal congestion, sore throat, difficulty swallowing)?
□ Yes □ No	Are you experiencing any strange symptoms (such as chills, muscle aches, diarrhea, headache, loss of taste or smell)?
2. In the past 14 days:	
□ Yes □ No	Have you had **close** contact* with someone who has been tested for COVID-19?
□ Yes □ No	Have you been in **close** contact* with a symptomatic person?

□ 'Yes' to any of the above:	**□ 'No' to all of the above:**
• Begin medical isolation • Provide mask • Notify Health Services of 'yes' response • Health Services Screening to follow	• Begin medical isolation, unless inmate is returning from outside hospital (refer to *the Patient Journey: Algorithm for return from hospitalization*) • Provide mask • Health Services Screening to follow

***Close contact** is defined as:

- Shared a close, confined space for 2 hours
- Close, face-to-face interaction for 15 minutes within 2m distance (may be cumulative)
- Household contacts (living or sleeping in the same home)

Note: If appropriate PPE was worn the individual is not a close contact

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