

## Border Clinical Management System

The following are images of the Border Clinical Management System (BCMS) in use by all providers of Whānau-HQ community isolation and quarantine.

The first three images show the clinical components of the standard initial health assessment. The fourth image is the routine daily check template.

Summary	Past Health and Wellbeing History - ask questions to find out about:					
Guest Information	Hypertension?	Yes	No	Previous heart attack or heart failure?	Yes	No
<b>Initial Assessment</b>	Diabetes?	Yes	No	Epilepsy?	Yes	No
Reg. Health Check	Asthma?	Yes	No	Other respiratory disease?	Yes	No
Clinical Encounter	Previous stroke?	Yes	No	Mental health and/or addiction?	Yes	No
Tasks	Cancer?	Yes	No	Kidney disease?	Yes	No
Inbox (Labs+)	Current pregnancy?	Yes	No	CPAP device used?	Yes	No
COVID Test Order						
Border Record	Other	Other				

Medication and Allergies							
Smoking?	Yes	No	Would you like NRT?	Yes	No		
Alcohol?	Yes	No	Drinks per week?	<10	10-16	>16	
Allergies?	Yes	No	Recreational drugs?	Yes	No		
Prescription medication or medical devices? ⓘ				Yes	No		
<div style="border: 1px solid #ccc; padding: 5px;"> <p>Details ⓘ List any medications, medical devices, recreational drugs here</p> </div>							
Able to manage meds independently?				Yes	No		
Sufficient supply for 14 days?		Yes	No	Taking immunosuppressant?		Yes	No

**Public health history**

Places visited in last 14 days **New Zealand**

Prev. positive COVID-19 test? **Yes** **No** High suspicion of prev. COVID-19? **Yes** **No**

Potential close contact with a COVID-19 positive person in the last 14 days? **Yes** **No**

COVID-19 vaccine? **Full** Partial Nil


Date	Vaccine Name	Country
[Redacted]	Pfizer/BioNtech	New Zealand
[Redacted]	Pfizer/BioNtech	New Zealand

**Regular Health Check 1** (Do you have any of the following symptoms?)

Face to Face **Telephone**

Fever/ Chills (feeling hot and cold)	<b>Yes</b> No	Shortness of breath	Yes <b>No</b>
Cough	Yes <b>No</b>	Sore throat	Yes <b>No</b>
Runny nose (Coryza)	Yes <b>No</b>	Loss of sense of smell / taste	Yes <b>No</b>
Headache	Yes <b>No</b>	Muscular Pain (Myalgia)	Yes <b>No</b>
Joint Pain	Yes <b>No</b>	Nausea/ Vomiting	Yes <b>No</b>
Diarrhoea			Yes <b>No</b>

Other **Other COVID related symptoms**

Note Timeline 	D0
Temperature	
Cough	
Runny nose	
Sore throat	
Shortness of breath	
Loss of smell / taste	
Headache	
Muscle / Joint Pain	
Nausea/Vomitting / Diarrhoea	
Other	
Acuity	
Mood	
Test	
SpO2	
Heart rate	
Respiration	
BP Systolic/Diastolic	

**Plan/Guideline**