

* Adapted from the original COVID-19 Yorkshire Rehab Screen

Covid 19 Yorkshire Rehab Screen (C19-YRS)- Manitoba*

When assessing a patient presenting with ongoing symptoms post-COVID, this tool provides guidance on a structured approach to reviewing complications. For most symptoms the rating scale is structured as a 1-10 scale. For patients indicating significant impact by responding 7 or higher you may need to explore these symptoms further to determine the clinical significance. Particularly for symptoms around cognition, anxiety, depression and PTSD positive responses will require further exploration.

The original C19-YRS was designed as a telephone interview, it can be adapted for an in person encounter.

Opening questions:

<p>Have you had any further medical problems or needed to go back to hospital since your discharge?</p> <p>Re-admitted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details:</p>
<p>Have you used any other health services since discharge (e.g. your GP?)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details:</p>

<p><i>I'll ask some questions about how you might have been affected since your illness. If there are other ways that you've been affected then there will be a chance to let me know these at the end.</i></p>			
1. Breathlessness	<p>On a scale of 0-10, with 0 being not breathless at all, and 10 being extremely breathless, how breathless are you:</p> <p>(n/a if does not perform this activity)</p>	Now	Pre-Covid
	a) At rest?	0-10: ____	0-10: ____
	b) On dressing yourself?	0-10: ____ N/a <input type="checkbox"/>	0-10: ____ N/a <input type="checkbox"/>
	c) On walking up a flight of stairs?	0-10: ____ N/a <input type="checkbox"/>	0-10: ____ N/a <input type="checkbox"/>

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<p>2. Laryngeal/ airway complications</p>	<p>Have you developed any changes in the sensitivity of your throat such as troublesome cough or noisy breathing? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>3. Voice</p>	<p>Have you or your family noticed any changes to your voice such as difficulty being heard, altered quality of the voice, your voice tiring by the end of the day or an inability to alter the pitch of your voice? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>4. Swallowing</p>	<p><i>Are you having difficulties eating, drinking or swallowing such as coughing, choking or avoiding any food or drinks?</i> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>5. Nutrition</p>	<p>Are you or your family concerned that you have ongoing weight loss or any ongoing nutritional concerns as a result of Covid-19? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Please rank your appetite or interest in eating on a scale of 0-10 since Covid-19 (0 being same as usual/no problems, 10 being very severe problems/reduction)</p> <p>0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>6. Mobility</p>	<p>On a 0-10 scale, how severe are any problems you have in walking about? 0 means I have no problems, 10 means I am completely unable to walk about.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>7. Fatigue</p>	<p>Do you become fatigued more easily compared to before your illness? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how severely does this affect your mobility, personal cares, activities or enjoyment of life? (0 being not affecting, 10 being very severely impacting)</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>8. Personal-Care</p>	<p>On a 0-10 scale, how severe are any problems you have in personal cares such as washing and dressing yourself? 0 means I have no problems, 10 means I am completely unable to do my personal care.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>9. Continence</p>	<p>Since your illness are you having any <u>new</u> problems with:</p> <ul style="list-style-type: none"> • controlling your bowel Yes <input type="checkbox"/> No <input type="checkbox"/> • controlling your bladder Yes <input type="checkbox"/> No <input type="checkbox"/>

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<p>10. Usual Activities</p>	<p>On a 0-10 scale, how severe are any problems you have in do your usual activities, such as your household role, leisure activities, work or study? 0 means I have no problems, 10 means I am completely unable to do my usual activities.</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>11. Pain/ discomfort</p>	<p>On a 0-10 scale, how severe is any pain or discomfort you have? 0 means I have no pain or discomfort, 10 means I have extremely severe pain</p> <p>Now: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p> <p>Pre-Covid: 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>12. Cognition</p>	<p>Since your illness have you had new or worsened difficulty with:</p> <ul style="list-style-type: none"> • concentrating? Yes <input type="checkbox"/> No <input type="checkbox"/> • short term memory? Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>13. Cognitive-Communication</p>	<p><i>Have you or your family noticed any change in the way you communicate with people, such as making sense of things people say to you, putting thoughts into words, difficulty reading or having a conversation?</i> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes: rate the significance of impact on a scale of 0-10 (0 being no impact, 10 being significant impact) 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/></p>
<p>14. Anxiety GAD-2</p>	<p>Over the last 2 weeks, how often have you been bothered by the following problems</p> <p>1. Feeling nervous, anxious or on edge 0 <input type="checkbox"/> not at all 1 <input type="checkbox"/> several days 2 <input type="checkbox"/> more than half the days 3 <input type="checkbox"/> nearly every day</p> <p>2. Not being able to stop or control worrying 0 <input type="checkbox"/> not at all 1 <input type="checkbox"/> several days 2 <input type="checkbox"/> more than half the days 3 <input type="checkbox"/> nearly every day</p> <p>If the total score is 3 or greater, further diagnostic evaluation for generalized anxiety is warranted</p> <p>How does this compare to any anxiety symptoms before your COVID illness? 1 <input type="checkbox"/> about the same; 2 <input type="checkbox"/> better 3 <input type="checkbox"/> worse 4 <input type="checkbox"/> not applicable – did not experience anxiety</p>
<p>15. Depression PHQ-2</p>	<p>Over the last 2 weeks, how often have you been bothered by the following problems</p> <p>1. Little interest or pleasure in doing things 0 <input type="checkbox"/> not at all 1 <input type="checkbox"/> several days 2 <input type="checkbox"/> more than half the days 3 <input type="checkbox"/> nearly every day</p> <p>2. Feeling down, depressed or hopeless</p>

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	<p> 0 <input type="checkbox"/> not at all 1 <input type="checkbox"/> several days 2 <input type="checkbox"/> more than half the days 3 <input type="checkbox"/> nearly every day If the total score is 3 or greater, major depressive disorder is likely. Individuals who screen positive should be further evaluated with the PHQ-9, other tests or direct interview How does this compare to any depression symptoms before your COVID illness? 1 <input type="checkbox"/> about the same; 2 <input type="checkbox"/> better 3 <input type="checkbox"/> worse 4 <input type="checkbox"/> not applicable, did not experience depression </p>
16. PTSD screen	<p> Considering your recent COVID illness/ COVID related hospital admission, In the past month have you: Had nightmares about the event(s) or thoughts about the event(s) when you did not want to Yes <input type="checkbox"/> No <input type="checkbox"/> Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> Been constantly on guard, watchful or easily startled? Yes <input type="checkbox"/> No <input type="checkbox"/> Felt numb or detached from people, activities, or your surroundings Yes <input type="checkbox"/> No <input type="checkbox"/> Felt guilty or unable to stop blaming yourself or others fro the event(s) or any problems the event(s) may have caused Yes <input type="checkbox"/> No <input type="checkbox"/> Does individual answer yes to 3 or more items Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, this is a positive screen for PTSD and further diagnostic evaluation is warranted </p>
17. Self Rated Health	<p> How would you rate your current health? Now: Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Bad <input type="checkbox"/> Pre-Covid: Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Bad <input type="checkbox"/> </p>
18. Vocation	<p> What is your employment situation and has your illness affected your ability to do your usual work? Occupation: _____ Employment status before Covid-19 Lockdown: _____ Employment status before you became ill: _____ Employment status now: _____ </p>

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19. Family/caregiver views	Do you think your family or caregivers would have anything to add from their perspective?
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Closing question

Are you experiencing any other new problems since your illness we haven't mentioned?

Any other discussion (clinical notes):