COVID-19 Screening form (May 22, 2020 version) Temperature reading_____

Staff screener: _____

Patient Name: _____ Patient age: _____

Who answered: ___ Patient ___ Other (specify) _____

Contact Method: ___ Phone ___ email ___ Other _____

1. Are you currently waiting for the results of a test for COVID-19? YES NO

2. Is this currently a period where you are required to self-isolate for 14 days? YES NO

3. Have you had any contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days? YES NO

4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? YES NO

5. Do you have any of the following symptoms, check box if answer is YES:

☐Fever, if yes temperature at appointment: _____.

☐New onset of cough	☐Worsening chronic cough	☐Shortness of breath
☐ Difficulty breathing	☐Sore throat	☐Difficulty swallowing
☐Chills	☐Headaches	☐Pink eye (conjunctivitis)

☐Unexplained fatigue/malaise/muscle aches (myalgias)
☐Nausea/vomiting, diarrhea, abdominal pain
☐Runny nose/nasal congestion without other known cause
☐Decrease/loss of sense of taste or smell

6. If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

YES NO

7. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder? YES NO

<u>Patient Acknowledgement: COVID-19 Pandemic</u>

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious***. For this reason, it is recommended to stay home and avoid close contact with other people when at all possible. I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 metres (6 feet) and I recognize ***it is not possible to maintain this distance while receiving dental treatment.***

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT _____ Date _____