COVID-19: SCREENING QUESTIONNAIRE

Patient name: _____ Email: _____

Have you travelled outside of Canada in the past 14 days? Yes □ No □

Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19?

Yes □ No □

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Public Health Services: _____ (Initial)

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease of loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose or nasal congestion without other known cause

Age: Below 70 □ Above 70 □

Ask if the person is 70 years of age or older

Are you experiencing any of the following symptoms?

• Delirium	Yes □	No □
• Unexplained or increased number of falls	Yes □	No □
• Acute functional decline	Yes □	No □
• Worsening of chronic conditions	Yes □	No □

If response to ALL of the screening questions is NO:
COVID Screen Negative

If response to ANY of the screening questions is YES:
COVID Screen Positive

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

Patient/Parent/Guardian Signature * Date*