Patient Screening Form

Staff Screener: ______________________________

Patient Name: ______________________________________ Age: _____

Who answered: ___ Patient ___ other (specify): ____________ Contact method: ___ Phone

	Pre Appoint ment		In Office		II Apt		III Apt		IV Apt	
Screening Date										
Did the person travel outside of Canada in the past 14 days	Yes	No	Y	N	Y	N	Y	N	Y	N
Has the person tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE	Yes	No	Y	N	Y	N	Y	N	Y	N
Does the person have any of the following symptoms (circle any that apply) • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills. Headaches • Unexplained fatigue/malaise/muscle aches (myalgia's) • Nausea/vomiting, diarrhea, abdominal pain • Pink eye (conjunctivitis) • Runny nose/nasal congestion without other known cause	Yes	No	Y	N	Y	N	Y	N	Y	N
If the person is 70 years of age or older, are they experiencing <u>any</u> of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions	Yes	No	Y	N	Y	N	Y	N	Y	N
Persons temperature 37.8C or greater	Yes	No	Y	N	Y	N	Y	N	Y	N

If the response is <u>yes</u> to any of the above questions, the person has screened positive. They should be instructed to call their primary care provider or Telehealth Ontario for further instructions.
Telehealth Ontario: 1-866-797-0000

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office. __________ (initial)

Patients Sign: