PATIENT SCREENING FORM

Staff Screener: _____

Patient Name: _____

Patient Age: _____

SCREENING QUESTIONS	PRE SCREEN	IN - OFFICE
Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at appointment: _____	Yes No	Yes No
Do you have any of these symptoms: Dry cough, shortness of breath, difficulty breathing, sore throat, runny nose or any nasal congestion, difficulty swallowing, decrease or loss of sense of smell or taste, chills, headaches, unexplained fatigue or muscle aches, nausea, vomiting, diarrhea, abdominal pain, pink eye	Yes No	Yes No
Have you had a confirmed case of COVID-19?	Yes No	Yes No
Have you been in contact with anyone that has been confirmed COVID-19 positive, or persons self-isolating because of a determined risk for COVID-19, or with anyone with acute respiratory illness?	Yes No	Yes No
Have you returned from travel outside of Canada in the last 14 days? Have you been in close contact with anyone that has travelled outside of Ontario in the past 14 days?	Yes No	Yes No
Are you over the age of 70 that have experienced any of the following symptoms: delirium, unexplained or increased number of falls, worsening of chronic conditions, or acute functional decline?	Yes No	Yes No

Patient Signature: _____ Date: _____