Patient Screening Form

Staff Screener: _____

Patient Name: _____

Who Answered: _____ Patient _____ Other (Specify) _____

Contact Method: _____ Phone _____ Email _____Other

Current Temperature (To be taken in office): _____

Screening Questions **(FOR PATIENT TO FILL OUT)**	Pre-Screen		In-Office	
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	YES	NO	YES	NO
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	YES	NO	YES	NO
Do you have any of the following symptoms: • 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 (myalgias) • Nausea/vomiting, diarrhea, abdominal pain • Pink Eye • Runny nose/nasal congestion without other known cause	YES	NO	YES	NO
Are you 70 years of age or older, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline or worsening chronic conditions?	YES	NO	YES	NO

Upon arriving at the office, please be prepared to:

- Sanitize your hands
- Answer the questions again
- Have their temperature taken
- Complete a form acknowledging the risk of COVID-19

For the time being:

- Only patients are allowed to come in the office
- **Please wait in your car until your appointment. Contact the office to let us know once you have arrived, and we will phone you back once we are ready to see you.**