APPOINTMENT DAY PATIENT SCREENING FORM

Date:

Patient Name: **Patient age:**

Who answered: **Patient** ☐ **Other** ☐ **(specify):**

Contact Method: **Cell Phone:** **email:**

Home Phone:

PLEASE SELECT YES OR NO IN ANSWER TO EACH QUESTION.

Screening Questions	APPT DAY
	YES/NO
Have you travelled outside of Canada in the past 14 days?	○ ○
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	○ ○
Do you have any of the following symptoms: • Fever greater than 38 degrees Celsius • 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 (conjunctivitis) • Runny nose/nasal congestion without other known cause	○ ○
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? ANSWER NO IF YOU ARE UNDER 70 YEARS OF AGE.	○ ○

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Signature of Patient/Parent/Guardian Date