MANDATORY COVID-19 PRESCREENING 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	PRE-SCREEN
	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.	○ ○

PATIENT ACKNOWLEDGEMENT:
COVID-19 PANDEMIC EMERGENCY DENTAL RISK

PLEASE READ THE PATIENT ACKNOWLEDGEMENT BELOW, AND CHECK EACH BOX AND SIGN AS INDICATED.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus **may not show symptoms and still be contagious**. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible.
I understand and agree: ☐

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and **I recognize it is not possible to maintain this distance while receiving dental treatment**. I understand and agree: ☐

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. I understand and agree: ☐

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**. I understand and agree: ☐

I agree to complete a COVID-19 screening questionnaire as required by the Ministry of Health.
I understand and agree: ☐

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. I understand and agree: ☐ If applicable, approximate date of test:

I confirm that I am not waiting for the results of a test for COVID-19. I understand and agree: ☐

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. I understand and agree: ☐

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic. ☐

SIGNATURE OF PATIENT, PARENT, or GUARDIAN Date

Adapted from Dental Association of PEI COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient.