Patient Screening Form

Patient Name: _____Age: _____

Appointment Date & Time: _____

If applicable, name of parent/guardian accompanying patient: _____

Screening Questions

Have you travelled outside of Canada in the past 14 days?	YES NO
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	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 (conjunctivitis) • Runny nose/nasal congestion without other known cause	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 of chronic conditions?	YES NO