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| ***Covid-19 Screening Questions*** | | | | ***Yes*** | ***No*** | ***Unknown*** |
| **Q1: Do you have a concern for a potential COVID-19 infection?**  *(e.g. is there an outbreak in the facility, are you waiting for COVID-19 test results, etc.? )* | | | |  |  |  |
| **Q2: Did You have close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days?** | | | |  |  |  |
| **Q3: 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?* | | | |  |  |  |
| **Q4: Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?** | | | |  |  |  |
| **Q5: Do You have any of the following symptoms?** | | | |  |  |  |
|  | *Fever* |  | *Chills* | | | |
|  | *New onset of cough* |  | *Headaches* | | | |
|  | *Worsening chronic cough* |  | *Unexplained fatigue/malaise/muscle aches (myalgias)* | | | |
|  | *Shortness of breath* |  | *Nausea/vomiting, diarrhea, abdominal pain* | | | |
|  | *Difficulty breathing* |  | *Pink eye (conjunctivitis)* | | | |
|  | *Sore throat* |  | *Runny nose/nasal congestion without other known cause* | | | |
|  | *Difficulty swallowing* |  | *Decrease or loss of sense of taste or smell* | | | |
| **Body Temperature (Measured at the Office) :** | | | | | | |
| 1. *Please* ***wear your own mask*** *all the time when you are at the clinic( if you Don’t have one please inform us, so one would be provided to you)* 2. *Please perform* ***Hand Hygiene*** *(washing with water and soap or sanitizing with hand rubs) UPON Arrival & After the appointments.* 3. ***Please inform the office if you experienced any symptoms of Covid-19 within 14 days after your appointment.*** | | | | | | |
| ***Name : Date : Signature :***  ***Office staff: date, time & initial of phone interview:*** | | | | | | |