Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Screener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Age:\_\_\_\_\_\_\_\_\_\_\_

 Who answered: Patient \_ Other (specify)

Contact Method: Phone \_ email \_ Other

|  |  |  |
| --- | --- | --- |
| Screening Questions | Pre-Screen | In-Office |
| 1. Do you have a fever or have felt hot or feverish anytime in the last two weeks?Patient temperature at appointment: \_ \_. If elevated, provide mask to patient. | YES | NO | YES | NO |
| 2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? | YES | NO | YES | NO |
| 3. Have you experienced a recent loss of smell or taste? | YES | NO | YES | NO |
| 4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? | YES | NO | YES | NO |
| 5. Have you returned from travel outside of Canada in the last 14 days? | YES | NO | YES | NO |
| 6. Have you returned from travel within Canada from a location known affected with COVID-19? | YES | NO | YES | NO |
| 7. Is your workplace considered high risk? | YES | NO | YES | NO |

Patient Vulnerability

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 8. Are you over the age of 70? | YES | NO | YES | NO |
| 9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder?  | YES | NO | YES | NO |

Any “yes” response for questions 1-9 must be discussed with the dentist or hygienist

 Patients:

* + - Only patients are allowed to come to the office.

If possible, please wait in your car until your appointment