

Patient Screening Form Patient Name: _____ Patient Age: ____ Date: _____

Staff Screener: _____

Who Answered: ____ Patient ____ Other (specify) _____

Contact Method: ____ Phone ____ email ____ Other (specify) _____

SCREENING QUESTIONS (COMPLETE THE PRE-SCREEN COLUMN 48 HOURS BEFORE APPOINTMENT)	Pre-Screen		In-Office	
Q1: Have you received your final (or second) vaccination dose more than 14 days ago? If NO, you must answer questions Q5 and Q6. If YES, you do not need to answer Q5 and Q6.	YES	NO	YES	NO
Q2: Do you have a confirmed case of COVID-19 or had close contact with a person who is a confirmed case of COVID-19?	YES	NO	YES	NO
Q3: Do you have any of the following: <ul style="list-style-type: none"> • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Decrease or loss of taste or smell • If adult >18 years of age: unexplained fatigue/ lethargy / malaise / muscle aches (myalgias) • If child <18 years of age: nausea/vomiting, diarrhea 	YES	NO	YES	NO
Q4: Have you tested positive for COVID-19 in the past 10 days or have you been told you should be isolating?	YES	NO	YES	NO
Q5: Have you travelled outside of Canada in the past 14 days?	YES	NO	YES	NO
Q6: Has the person had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	YES	NO	YES	NO

Forehead Temperature Readings: Reading 1 _____°C

SpO2 _____%

(Will be measured at office) Reading 2 _____°C

*Temperature of 38°C or greater is considered a fever and SpO2 values below 90% are considered low.