SCREENING FORM FOR PATIENTS/ACCOMPANYING PERSONS

IMPORTANT: Please call us if you answer yes to one of these questions.

Name of person screened: _____ Please indicate if the above name refers to the screening form for the patient or the accompanying person: Name of patient: _____ ☐ Patient ☐ Accompanying person	PRE-APPT. Date:	CLINIC Date:
1. Do you have one of the following symptoms?		
• Fever	☐ Yes ☒ No	☐ Yes ☒ No
• Cough	☐ Yes ☒ No	☐ Yes ☒ No
• Difficulty breathing	☐ Yes ☒ No	☐ Yes ☒ No
• Sudden loss of smell or taste	☐ Yes ☒ No	☐ Yes ☒ No
• Out of breath	☐ Yes ☒ No	☐ Yes ☒ No
• Sore throat	☐ Yes ☒ No	☐ Yes ☒ No
2. Do you have at least two of the following symptoms?		
• Intense fatigue	☐ Yes ☒ No	☐ Yes ☒ No
• Headache	☐ Yes ☒ No	☐ Yes ☒ No
• Muscle pain (not related to physical exertion)	☐ Yes ☒ No	☐ Yes ☒ No
• Significant loss of appetite	☐ Yes ☒ No	☐ Yes ☒ No
• Nausea and/or vomiting	☐ Yes ☒ No	☐ Yes ☒ No
• Diarrhea	☐ Yes ☒ No	☐ Yes ☒ No
• Abdominal pain	☐ Yes ☒ No	☐ Yes ☒ No
3. Are you actually in isolation because of a positive result to a COVID-19 test?	☐ Yes ☒ No	☐ Yes ☒ No
4. Have you received a recommendation to take a screening test or are you awaiting the result?	☐ Yes ☒ No	☐ Yes ☒ No
5. Have you been instructed to place yourself in preventive isolation? (Ex.: following a trip outside of Canada in the last 14 days, contact with a confirmed case of COVID-19)?	☐ Yes ☒ No	☐ Yes ☒ No
Signature of person who has completed the form (patient or office personnel): Signature pre-appt.: _____ Signature clinic: _____		
Also, you can bring interior shoes or slippers for your comfort since we will ask you to remove yours boots in the clinic.		