PRE-TREATMENT COVID-19 HEALTH SCREENING

JUNE 2020

PATIENT NAME: ____ **DATE:** ________________________

PHONE #: ______________________________ **CONDUCTED:** ❑ **In-Person** ❑ **Telephone** ❑ **Electronic**

Have you travelled outside Canada in the last 14 days?		❑ Yes ❑ No If yes, where? ___________________________	
Have you been in contact with someone who was diagnosed with COVID-19 recently?		❑ Yes ❑ No	
Have you worked in/volunteered at/visited a senior's residence, nursing home, hospital, ambulance or medical clinic in the last 14 days?		❑ Yes ❑ No	
Do you have a fever? Have you felt hot or feverish in the last 2 days?		❑ Yes ❑ No	
Did you take any fever medications? Ibuprofen, acetaminophen, flu buster?		❑ Yes ❑ No	
Are you experiencing shortness of breath?		❑ Yes ❑ No	
Have you experienced a new onset of cough?		❑ Yes ❑ No	
Have you lost your sense of smell or taste?		❑ Yes ❑ No	
Are you experiencing any of the following symptoms?			
Fatigue	❑ Yes ❑ No	Chills / Body Aches	❑ Yes ❑ No
Sore Throat	❑ Yes ❑ No	Headache	❑ Yes ❑ No
Hoarse Voice	❑ Yes ❑ No	Runny / Congested Nose	❑ Yes ❑ No
Nausea / Vomiting	❑ Yes ❑ No	Difficulty Swallowing	❑ Yes ❑ No
Diarrhea	❑ Yes ❑ No		
For those 70 years of age or older: Are you experiencing any of the following symptoms?			
Delirium	❑ Yes ❑ No	Unexplained or increased falls	❑ Yes ❑ No
Recent functional decline	❑ Yes ❑ No	Worsening of chronic conditions	❑ Yes ❑ No

If any of the above questions were answered 'Yes' = POSITIVE COVID-19 health screen.
Please call the clinic at 416-665-1600 as soon as possible for further guidance and to reschedule your appointment for at least 14 days from now.

SIGNATURE OF PATIENT: ____