COVID-19 PATIENT SCREENING FORM

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Have you travelled outside of Canada in the past 14 days?

Yes _____ **No** _____

Have you tested positive for COVID-19 OR had a close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

Yes _____ **No** _____

Do you have any of the following symptoms:

1. **Yes** _____ **No** _____ Fever.
2.
3. **Yes** _____ **No** _____ New onset of cough.
4. **Yes** _____ **No** _____ Worsening chronic cough.
5. **Yes** _____ **No** _____ Shortness of breath.
6. **Yes** _____ **No** _____ Difficulty breathing.
7. **Yes** _____ **No** _____ Sore throat.
8. **Yes** _____ **No** _____ Difficulty swallowing.
9. **Yes** _____ **No** _____ Decrease or loss of sense of taste or smell.
10. **Yes** _____ **No** _____ Chills.
11. **Yes** _____ **No** _____ Headaches.
12. **Yes** _____ **No** _____ Unexplained fatigue/malaise/muscle aches (myalgias).
13. **Yes** _____ **No** _____ Nausea/vomiting, diarrhea, abdominal pain.
14. **Yes** _____ **No** _____ Pink eye (conjunctivitis).
15. **Yes** _____ **No** _____ Runny nose/nasal congestion without other known cause.

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?

Yes _____ **No** _____

Name: _____ Date: _____

Signature: _____