Patient Screening Form

Staff screener: _____

Patient Name: _____ Patient age: _____

Who answered: ☐ Patient ☐ Other (specify) _____

Contact Method: ☐ Phone ☐ email ☐ Other _____

Identify yourself and explain the purpose of the call, which is to determine whether there are any special considerations for their dental appointment. Have the patient answer the following questions.

SCREENING QUESTIONS	Pre-Screen	In-Office
Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?	YES NO	YES NO
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	YES NO	YES NO
Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches (myalgias) • Nausea/vomiting, diarrhea, abdominal pain Pink eye (conjunctivitis) • Runny nose/nasal congestion without other known cause	YES NO	YES NO
Are you 70 years of age or older, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES NO	YES NO
Do you have any of the following? Heart Disease, Lung Disease, Kidney Disease, Diabetes or any other auto-immune disorder?	YES NO	YES NO

Please be advised, all patients will have to:

- Sanitize their hands.
- Wear a mask
- Answer the questions again.
- Possibly have their temperature taken.
- Complete a form acknowledging the risk of COVID-19.

Please Note:

- Only patients are allowed to come to the office.
- If possible, to wait in their car until their appointment, call the office when they arrive