COVID-19 Patient Screening Form

Screening Questions

1.	Do you have a fever or have felt hot or feverish anytime in the last 10 days?	□ Yes	□ No
2.	Do you have any of these symptoms:		
	a. New or worsening cough?	□ Yes	□ No
	b. New or worsening shortness of breath?	□ Yes	□ No
	c. Difficulty Breathing?	□ Yes	□ No
	d. Sore Throat or painful swallowing?	□ Yes	□ No
	e. Runny Nose?	□ Yes	□ No
3.	Have you experienced a recent loss of smell or taste?	□ Yes	□ No
4.	Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? (Healthcare workers who have worn appropriate PPE may answer No)	□ Yes	□ No
5.	Have you returned from travel outside of Canada in the last 14 days?	□ Yes	□ No
6.	Have you returned from travel within Canada from a location known affected with COVID-19 in the last 14 days?	□ Yes	□ No
7.	Is your workplace considered high risk? (Healthcare workers who have worn appropriate PPE may answer No)	□ Yes	□ No
8.	Are you over the age of 65?	□ Yes	□ No
9.	Do you have any of the following: Heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder?	□ Yes	□ No

Patient Name: _____

Signature: _____ Date: _____

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