

COVID-19

PATIENT SCREENING FORM

Patient Name John Smith

SCREENING QUESTIONS

1. Do you have a fever or have felt hot or feverish anytime in the last two weeks? Yes

2. Do you have any of the following symptoms:

- Dry cough Shortness of breath Difficulty breathing Sore throat
 Runny nose Sneezing Post-nasal drip

3. Have you experienced a recent loss of smell or taste? Yes

4. Have you been in contact with any confirmed COVID-19 positive patients, or person self-isolating because of a determined risk for COVID-19? Yes

5. Have you returned from travel outside of Canada in the last 14 days? Yes

6. Have you returned from travel within Canada from a location known affected by COVID-19? Yes

7. Is your workplace considered high risk? Yes

PATIENT VULNERABILITY

8. Are you over the age of 70? Yes

9. Do you have any of the following conditions?

- Heart disease Lung disease Kidney disease diabetes Auto-immune disorder

✓ I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand the novel coronavirus has a long incubation period during which carries of the virus may not show symptoms and still be contagious. For this reason, it is recommended to stay home and avoid close contact with other people when at all possible.

✓ I understand that it is possible that oral surgery/dental procedures can create water and/or blood spray, which is one important way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus.

✓ I understand the federal and provincial governments have asked individuals to maintain social distancing of at least 2 meters (6 feet) and I recognize it is not possible to maintain this distance while receiving dental treatment.

✓ I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of the dental procedures, that I have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office.

✓ I confirm that I have NOT tested POSITIVE for COVID-19.

✓ I confirm that I am not waiting for the results of a test for COVID-19.

✓ I confirm that this is not currently a period where I required to self-isolate for 14 days.

✓ I confirm that I do NOT have any TWO or MORE of the following symptoms of COVID-19: fever, new or worsening cough, sore throat runny nose or headache.

✓ I will not come to the clinic if I develop any symptoms that are listed above and will call immediately.

✓ I verify that the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

Patient Signature

