COVID-19

PATIENT SCREENING & TREATMENT CONSENT FORM

Patient Name	Jane Doe	**Date of birth**	12/03/2020

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

Do you have any of the following symptoms:

- [X] Dry cough
- [ ] Sore throat
- [ ] Difficulty swallowing
- [ ] Digestive issues
- [X] Headache that is unusual or long lasting headache
- [ ] Shortness of breath
- [ ] Runny nose
- [X] Stuffy or congested nose
- [ ] Muscle aches
- [ ] For young children and infants: sluggishness or lack of appetite
- [ ] Difficulty breathing
- [ ] Cough that's new or worsening
- [ ] Pink eye
- [ ] Extreme tiredness that is unusual
- [ ] Falling down often

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

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

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

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

Are you over the age of 60? Yes

Do you have any of the following conditions?

- [X] Heart disease
- [ ] Lung disease
- [X] 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 due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of the medical procedures, that I have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the medical office.

✔ 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 medical treatment.

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

Signature