NAPA VALLEY DENTAL CENTRE – KLEINBERG DENTISTRY

COVID-19 Screening Form for Patients

Background Question

1. **Did you receive your final or second vaccination dose more than 14 days ago?** **YES NO**

Screening Questions

2. **Do you have any of the following symptoms?** **YES NO**
   - **Fever and/or chills**
   - **New onset of cough or worsening chronic cough**
   - **Shortness of breath**
   - **Decrease or loss of sense of taste or smell**
   - **If adult > 18 years of age: unexplained fatigue/lethargy/malaise/muscle aches (myalgias)**
   - **If child < 18 years of age: nausea/vomiting, diarrhea**

3. **Have you tested positive for COVID-19 in the past 10 days or have you been told you should be isolating?** **YES NO**

Question 4 and Question 5 should only be asked if the person is not fully immunized (i.e. they answered "No" to Question 1)

4. **Did you travel outside of Canada in the past 14 days?** **YES NO**

5. **Have you had close contact with a confirmed case of COVID-19 without wearing appropriate Personal Protective Equipment (PPE)?** **YES NO**

If response to ALL of the screening questions is NO: COVID SCREEN NEGATIVE_____(Initial)

If response to ANY of the screening questions is YES: COVID SCREEN POSITIVE_____(Initial)

If response to ALL of the screening questions is UNKNOWN: COVID SCREEN UNKNOWN _____(Initial)

If response to ANY of the screening questions is NO and UNKNOWN: COVID SCREEN UNKNOWN _____(Initial)

Patient name (print)_____Date_____

Revised September 2021