NAPA VALLEY DENTAL CENTRE – KLEINBERG DENTISTRY

COVID-19 Screening Form for Patients

1. Have you returned from travel outside of Canada in the past 14 days? YES NO
2. Have you tested positive for COVID-19? YES NO
3. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate Personal Protective Equipment (PPE)? YES NO
4. Do you have any of the following symptoms? YES NO
   - 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 or nasal congestion without other known cause

6. If the person is 70 years of age or older, are they experiencing any of the following symptoms:

delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? 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)

Patient name (print)_____Date_____

(FOR OFFICE USE)

Temperature_____

Staff signature: _____