COVID-19 regular screening questions to be asked and signed by the patient at every visit.

1.) **Have you had a fever in the last 24 hrs, or do you currently have a fever?**
YES NO

2.) **Do you have a new onset of a cough?**
YES NO

3.) **Do you have a chronic cough that has gotten worse?**
YES NO

4.) **Do you have shortness of breath, or difficulty breathing (not related to another diagnosis)?**
YES NO

5.) **Have you had close contact with anyone with an acute respiratory illness or travelled outside of Canada in the past 14 days?**
YES NO

6.) **Do you have a confirmed case of COVID-19?**
YES NO

7.) **Have you been tested for COVID-19 and still waiting for your results?**
YES NO

8.) **Have you had close contact with anyone with a confirmed case of COVID-19, or have you had close contact with a suspected Covid-19 case that has not been confirmed?**
YES NO

9.) **If you had close contact with a confirmed case of COVID-19 or a suspected case of COVID-19 did you wear the required PPE according to the type of duties you were performing (e.g. goggles, gloves, mask and gown or N95 with aerosol generating medical procedures when you had close contact with a suspected or confirmed case of COVID-19?**

YES NO NOT APPLICABLE

10.) Do you have any two of the following symptoms listed below: Please circle YES if you have <u>two</u> or more of these symptoms or NO if one or none apply:

YES NO

Sore Throat Runny nose/sneezing Nasal Congestion Hoarse Voice

Difficulty Swallowing Decreased or loss of sense of smell Chills

Headaches Unexplained fatigue/malaise Diarrhea Abdominal Pain

Nausea/Vomiting

11.) If over 65 Years of age are you experiencing any of the following listed below. Please circle YES or NO as well as any symptoms that apply: YES NO

Delirium Falls Acute Functional Decline Worsening of chronic conditions

I, _____ acknowledge that to my knowledge I have understood the above screening questions and have answered the above screening questions truthfully. I am of sound, clear mind when answering the above questions.

Date:_____ Sign Name:_____

Clinic Name:_____

Screened by:_____

Screening Passed: YES NO

IF NO: What measures were taken? _____

_____

_____