

Patient Name: **Team Screener**:

Temp:

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| Pulse: Date: |  |  |
| **Pre-Screen** | **In-Office** |
| Have you had close contact with anyone with acute respiratoryillness or travelled outside of Ontario in the past 14 days? | YESNO | YESNO |
| Do you have a CONFIRMED case of COVID- 19 or had closecontact with a confirmed case of COVID- 19? | YEsNO | YEsNO |
| Do you have any of the following symptoms:A - FeverB - Worsening chronic coughC - Shortness of Breath D - New onset of cough E - Sore ThroatF - Difficulty breathingG - Decrease or loss of sense of taste or smell H - ChillsI - HeadachesJ - Unexplained fatigue / malaise / muscle aches (myalgias) K - Nausea / Pink eye (conjunctivitis) / VomitingDiarrhea / Abdominal Pain | YESNO | YESNO |
| Are you 70 years of age or older, experiencing any of the following:A - Delirium, Worsening of chronic conditions, Unexplained or increased number of falls or acute functional decline | YESNO | YESNO |