

Patient Name: **Team Screener**:

Temp:

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| Pulse: Date: |  |  |
| **Pre-Screen** | **In-Office** |
| Have you had close contact with anyone with acute respiratory  illness or travelled outside of Ontario in the past 14 days? | YES  NO | YES  NO |
| Do you have a CONFIRMED case of COVID- 19 or had close  contact with a confirmed case of COVID- 19? | YEs  NO | YEs  NO |
| Do you have any of the following symptoms:  A - Fever  B - Worsening chronic cough  C - Shortness of Breath D - New onset of cough E - Sore Throat  F - Difficulty breathing  G - Decrease or loss of sense of taste or smell H - Chills  I - Headaches  J - Unexplained fatigue / malaise / muscle aches (myalgias) K - Nausea / Pink eye (conjunctivitis) / Vomiting  Diarrhea / Abdominal Pain | YES  NO | YES  NO |
| 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 | YES  NO | YES  NO |