**Screening Checklist for Patients**

Have you travelled outside of Canada in the past 14 days? Y N

Have you tested positive for Covid-19 or had close contact

with a confirmed case of Covid-19 without wearing appropriate PPE? Y N

Have you had any of the following symptoms?

* Fever Y N
* New onset of cough Y N
* Worsening chronic cough Y N
* Shortness of breath Y N
* Difficulty breathing Y N
* Sore Throat or Hoarse voice Y N
* Difficulty swallowing Y N
* Decrease in sense of taste or smell Y N
* Chills Y N
* Headaches Y N
* Runny Nose or Nasal Congestion without known cause Y N
* Unexplained fatigue/ muscle aches Y N
* Nausea/vomiting, diarrhea, abdominal pain Y N
* Pink Eye (conjunctivitis) Y N

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen Levels: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If a patient answers yes to any of the screening questions or has a fever, we will ask that they reschedule their appointment.