Patient Screening Form

Screening Questions	Pre-Screen	
Do you have a fever or have felt hot or feverish anytime in the last two weeks?	Yes ☐	No ☐
Do you have dry cough?	Yes ☐	No ☐
Do you have shortness of breath? Difficulty breathing?	Yes ☐	No ☐
Do you have sore throat?	Yes ☐	No ☐
Do you have runny nose?	Yes ☐	No ☐
Have you experienced a recent loss of smell or taste?	Yes ☐	No ☐
Have you been in contact with any confirmed COVID-19 positive patients ,or persons isolating because of a determined risk for COVID-19?	Yes ☐	No ☐
Have you returned from travel outside of Canada in the last 14 days?	Yes ☐	No ☐
Have you returned from travel within Canada from a location known affected with COVID-19?	Yes ☐	No ☐
Are you over the age of 60?	Yes ☐	No ☐

Patient Screening Form

Screen Questions	Pre-Screen	
Do you have Heart disease/ lung disease/ kidney disease?	Yes ☐	No ☐
Do you have diabetes?	Yes ☐	No ☐
Do you have any auto-immune disorder?	Yes ☐	No ☐
Do you have nasal congestion/ hoarse voice?	Yes ☐	No ☐
Do you have difficulty swallowing?	Yes ☐	No ☐
Do you have chills?	Yes ☐	No ☐
Do you have headaches?	Yes ☐	No ☐
Do you have unexplained fatigue/ malaise	Yes ☐	No ☐
Do you have diarrhea?	Yes ☐	No ☐
Do you have abdominal pain?	Yes ☐	No ☐
Do you have nausea/ vomiting?	Yes ☐	No ☐