Coronavirus (COVID-19) Screening Questionnaire

- Please provide details prior to your next appointment.
- Date

Personal Information:

- Name
- Address
- Phone Number

Screening Questions:

- Q1: Did the person have close contact with anyone with acute respiratory Illness, anyone that tested positive for Covid-19, waiting for test results, should be self isolating or who has travel outside of Canada's capital (area) in the past 14 days?
  Capital includes both side of the Ottawa river in Ontario & Quebec.
- Q2: Does the person have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
- Q3: Does the person have any of the following symptoms:
  You can choose more than one. Fever New onset of cough Worsening chronic Cough Shortness of breath Difficulty breathing Sore throat Difficulty swallowing Decrease or loss of sense of taste or smell Chills Headaches Unexplained fatigue / malaise / muscle aches (myalgias) Nausea/vomiting, diarrhea, abdominal pain Pink eye (conjunctivitis) Runny nose/nasal congestion without other known cause
- Q4: If the person is 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

Patient Declaration:

- Patient Declaration
  I/We hereby confirm that the information provided herein is accurate, correct and complete and that the documents submitted along with this application form are genuine. Yes

Verification

- Please enter any two digits * Example: 12
- Submit