



## Patient Screening

- Guelph: 261 Edinburgh Rd, S.  
 Fergus: 749 St. Andrew St, W

### Patient:

	PRE-APPOINTMENT	IN-OFFICE
Screening Date:		
Did the person have close contact with anyone with acute respiratory illness <u>or</u> travelled outside of Ontario in the past 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the person have a confirmed case of COVID-19 <u>or</u> had close contact with a confirmed case of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the person have any of the following symptoms? ( <i>circle any that apply</i> ) <ul style="list-style-type: none"> <li>• Fever</li> <li>• New onset of cough</li> <li>• Worsening chronic cough</li> <li>• Shortness of breath</li> <li>• Difficulty breathing</li> <li>• Sore throat</li> <li>• Difficulty swallowing</li> <li>• Decrease or loss of sense of taste or smell</li> <li>• Chills</li> <li>• Headaches</li> <li>• Unexplained fatigue/malaise/muscle aches (myalgias)</li> <li>• Nausea/vomiting, diarrhea, abdominal pain</li> <li>• Pink eye (conjunctivitis)</li> <li>• Runny nose/nasal congestion without other known cause</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the person is 70 years of age or older, are they experiencing <u>any</u> of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person's temperature 37.8°C or greater		<input type="checkbox"/> Yes <input type="checkbox"/> No

If the response is **Yes** to any of the above questions, the person has screened **Positive**.

They should be instructed to call their primary care provider or Telehealth Ontario for further instructions. Telehealth Ontario: 1-866-797-0000

Patient has acknowledged that at the time of attending the office on \_\_\_\_\_ (Date) they have not presented with any symptoms and documents that they have answered the questionnaire truthfully. This is an important consideration as majority of denture patients fall into the most vulnerable patient groups. **Patients are requested to inform the office staff if they experience any symptoms of COVID19 within the next 14 days.**

\_\_\_\_\_  
 Signature for pre screening complete  
 (staff)

\_\_\_\_\_  
 Signature for screening in office appointment completed  
 (staff)