COVID-19 Patient Screening

Name: _____ Address: _____

Date of Birth: _____ Date: _____

Please answer the following questions by circling the appropriate response

Did you have close contact with anyone with acute respiratory Illness in the last 14 days? Yes No

Have you travelled outside of Ontario in the past 14 days? Yes No

Do you have a confirmed case of COVID-19? Yes No

Have you had close contact with a confirmed case of COVID-19? Yes No

Do you have any of the following symptoms:

- Fever Yes No
- New onset of cough Yes No
- Worsening chronic cough Yes No
- Shortness of breath Yes No
- Difficulty breathing Yes No
- Sore throat Yes No
- Difficulty swallowing Yes No
- Decrease or loss of sense of taste or smell Yes No
- Chills Yes No

• Headaches Yes No

•Unexplained fatigue/malaise/muscle aches (myalgias) Yes No

•Nausea/vomiting, diarrhea, abdominal pain Yes No
•Pink eye (conjunctivitis) Yes No

•Runny nose/nasal congestion without other known cause Yes No

Please answer the following questions if you are 70 years of age or older

Are you experiencing any of the following symptoms:

Delirium Yes No

Unexplained or increased number of falls Yes No

Acute functional decline Yes No

Worsening of chronic conditions Yes No