COVID-19 Screening Questions

Patient Name: _____ **Date:** _____

1. Have you traveled outside of Canada in the last 14 days? ☐ Yes ☐ No

2. Have you had contact with anyone with confirmed or suspected COVID-19 in the last 14 days? ☐ Yes ☐ No

3. Have you had any of the following symptoms in the last 14 days: If **Yes**, please check which of the following: ☐ Yes ☐ No

   - ☐ **Fever over 37.7 degrees**
   - ☐ **Difficulty breathing**
   - ☐ **Cough**

4. Are you currently experiencing a fever over 37.7 degrees, difficulty breathing or cough? ☐ Yes ☐ No

If you answered **Yes** to questions **1** *and/or* **2**:

Please stay home, self isolate for 2 weeks and call 1-866-797-0000 or your primary healthcare provider for further direction.

If you answered **Yes** to questions **3** *or* **4**:

Please stay home, self isolate and call 1-866-797-0000.

Please do NOT visit any medical facility, including the ER, unless you are severely ill. Please call ahead and let them know why you are coming. Do not get close to anyone with a compromised immune system or other underlying condition.

Completed By: _____

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