

Coronavirus COVID-19

Leaflet 2A: SCREENING FORM FOR PATIENTS/ACCOMPANYING PERSONS (D,H,A,T,DD,P)

Name of person screened: _____	PRE-APPT.	CLINIC
Please indicate if the above name refers to the screening form for the patient or the accompanying person: <input type="checkbox"/> Patient <input type="checkbox"/> Accompanying person – Name of patient: _____	Date:	Date:
1-Have you tested positive for COVID-19 in the last 21 days or have you been told that you should be tested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any of the following conditions:		
2-Fever (over 38°C or 100.4°F)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3-New cough or worsening chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4-Breathing difficulties (e.g., shortness of breath, difficulty speaking)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5-Sudden loss of smell (with or without loss of taste)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6-Muscle pain, headache, intense fatigue or significant loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7-Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8-Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9-Do you have a health issue that might explain the symptoms described above? If so, specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
10-Have you been in close contact (at least 15 minutes at less than 2 metres) with a confirmed or suspected case of COVID-19?^a	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature of person who has completed the form (patient or office personnel):		
Signature pre-appt.: _____ Signature clinic: _____		
THIS SECTION IS RESERVED FOR DENTAL CLINIC PERSONNEL <ul style="list-style-type: none"> • <i>If the patient has answered YES to at least one of the following conditions: SUSPECTED/CONFIRMED STATUS.</i> <ul style="list-style-type: none"> ✓ <u>YES</u> to question 1 ✓ <u>YES</u> to at least one of the questions from 2 to 5, without any other apparent cause (question 9) ✓ <u>YES</u> to at least one of the questions from 6 to 8, without any other apparent cause (question 9); ✓ <u>YES</u> to question 10. • <i>Any other answer: ASYMPTOMATIC STATUS.</i> <p>Check off the box of patient's COVID-19 status: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Suspected/Confirmed</p> <p>If the patient is considered a suspected/confirmed case of COVID-19, consult the dentist before making an appointment.</p>		

^a This condition excludes health workers who have cared for confirmed or suspected cases of COVID-19 wearing appropriate personal protective equipment.