PATIENT SCREENING PROTOCOL

File # _____

Name: _____ **Date:** _____

CHECK ALL THAT APPLY

DO YOU HAVE 1 (ONE) OR MORE OF THE FOLLOWING:

YES NO

___ ___ **FEVER**
___ ___ **NEW ONSET OF COUGH**
___ ___ **WORSENING CHRONIC COUG**
___ ___ **SHORTNESS OF BREATH, OR DIFFICULTY BREATHING**
___ ___ **CLOSE CONTACT WITH ANYONE WITH ACUTE RESPIRATORY ILLNESS**
___ ___ **TRAVELLED OUTSIDE OF ONTARIO IN THE PAST 14 DAYS**
___ ___ **CLOSE CONTACT WITH ANYONE WITH CONFIRMED CASE OF COVID-19**

DO YOU HAVE 2 (TWO) OR MORE OF THE FOLLOWING:

___ ___ **SORE THROAT**
___ ___ **RUNNY NOSE**
___ ___ **HOARSE VOICE**
___ ___ **DIFFICULTY SWALLOWING**
___ ___ **DECREASE OR LOSS OF SENSE OF SMELL**
___ ___ **CHILLS**
___ ___ **HEADACHES**
___ ___ **UNEXPLAINED FATIGUE/MALAISE**
___ ___ **DIARRHEA**
___ ___ **ABDOMINAL PAIN**
___ ___ **NAUSEA / VOMITTING**

IF OVER 65 YOA, ARE YOU EXPERIENCING:

___ ___ **DELIRIUM** (an acutely disturbed state of mind and is characterized by restlessness, illusions, and incoherence of thought and speech)
___ ___ **FALLS**
___ ___ **WORSENING OF CHRONIC CONDITIONS**
___ ___ **ACUTE FUNCTIONAL DECLINE** (A new loss of independence in self-care capabilities and is typically associated with deterioration in mobility and in the performance of activities of daily living (ADLs) such as dressing, toileting, and bathing)

If you answered YES to any of these questions, you should:

NOT ATTEND THE OFFICE FOR 14 DAYS;
COMPLETE THE ONTARIO GOVERNMENT'S SELF ASSESSMENT; and
CONTACT YOUR FAMILY PHYSICIAN

Dates screened _____