PATIENT SCREENING FORM

PATIENT NAME：_____

DATE：_____

	Screening Questions	In-office	
Q1:	Are you fully vaccinated against COVID-19 and/or aged 11 or younger?	Yes ◯	No ◯
Q2:	In the last 14 days, have you travelled outside of Canada and NOT been exempt from federal quarantine requirements?	Yes ◯	No ◯
Q3:	In the last 5 days (if fully vaccinated)/ 10 days (if unvaccinated or immunocompromised), have you experienced any of these symptoms? • Fever and/or chills • Cough or barking cough • Shortness of breath • Decrease or loss of taste or smell • Muscle aches/joint pain • Extreme tiredness • Sore throat • Runny or stuffy/congested nose • Headache • Nausea, vomiting and/or diarrhea	Yes ◯	No ◯
Q4:	Do any of the following apply? • You live with someone who is currently isolating because of a positive COVID-19 test • You live with someone who is currently isolating because of COVID-19 symptoms • You live with someone who is isolating while waiting for COVID-19 test results	Yes ◯	No ◯
Q5:	In the last 5 days (if fully vaccinated)/ 10 days (if unvaccinated or immunocompromised), have you tested positive on a rapid antigen test, molecular test, or home-based self-testing kit?	Yes ◯	No ◯
Q6:	Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?	Yes ◯	No ◯