SALMON ARM Dental

PATIENT SCREENING: COVID-19

NAME: _____

PHONE NUMBER: _____

DATE: _____

Screening Questions

1) Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient Temperature at appointment _____.	Yes	No
2) Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny Nose? Sneezing? Post-nasal drip?	Yes	No
3) Have you experienced a recent loss of smell or taste?	Yes	No
4) Have you been in contact with confirmed COVID-19 positive patients or persons self-isolating because of a determined risk for COVID-19?	Yes	No
5) Have you returned from travel outside of Canada in the past 14 days?	Yes	No
6) Have you returned from travel within Canada from a location known to be affected with COVID-19	Yes	No
7) Is your workplace considered high risk?	Yes	No
8) Have you been in close contact with anyone presenting any of the COVID-19 symptoms?	Yes	No
9) Do you consent to call Salmon Arm Dental if you become COVID-19 positive within the next 2 weeks to inform us of possible exposure?	Yes	No

Patient Vulnerability

10) Are you over the age of 70?	Yes	No
11) Do you have any of the following: Heart Disease? Lung Disease? Kidney Disease? Diabetes? Any Auto-immune Disorder?	Yes	No

Signature of Patient / Guardian: _____