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 within the past 14 days?	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: _____

SALMON ARM Dental

PATIENT ACKNOWLEDGEMENT
of COVID-19 Pandemic Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated

I understand there is currently a health pandemic associated with COVID-19 and the novel coronavirus.	(Initial)
I understand public health authorities have recommended maintaining social distancing of at least 2 meters (6 Feet) and it is not possible to maintain this distance while receiving dental treatment.	(Initial)
I understand that oral surgery/dental procedures can create water and/or blood spray, and that there may be an elevated risk of contracting and spreading the novel coronavirus in a dental office.	(Initial)
I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache, and that this is not currently a period where I am required to self-isolate for 14 days.	(Initial)
I confirm that I have not tested possitive for COVID-19 and that I am not currently waiting for the results of a test for COVID-19.	(Initial)
I hereby consent to have dental treatment completed during the COVID-19 pandemic	(Initial)

Signature of Patient / Guardian: _____ Date: _____