

Screen Questions for COVID-19

Patient Name: _____ Temperature: _____

Please circle yes or no.

1. Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days. **YES NO**
2. Have you been in close contact with a confirmed case of COVID-19? **YES NO**
3. Have you been confirmed to have COVID-19? **YES NO**
4. Do you have any of the following symptoms:

Fever	YES	NO
New onset of cough	YES	NO
Worsening chronic cough	YES	NO
Shortness of breath	YES	NO
Difficulty breathing	YES	NO
Sore throat	YES	NO
Decrease or loss of sense of taste or smell	YES	NO
Chills	YES	NO
Headaches	YES	NO
Unexplained fatigue/malaise/muscle aches	YES	NO
Nausea/vomiting, diarrhea, abdominal pain	YES	NO
Pink eye	YES	NO
Runny nose/nasal congestion without know cause	YES	NO
Have you been tested for COVID-19	YES	NO

5. If you are over the age of 70 please **circle** if you are experiencing any of these symptoms: delirium, unexplained or increased number of fall, acute functional decline, or worsening of chronic conditions?

Signature

Date

Screener