PATIENT SCREENING FORM

Use this form to screen patients before their appointment and when they arrive for their appointment.

Staff screener: _____

Patient Name: _____Patient age: _____

Who answered: _____ Patient _____ Other (specify): _____

Contact Method: _____ Phone _____ email _____

Date of pre-screening:_____ Date of in-office screening:_____

Identify yourself and explain the purpose of the call, which is to determine whether there are any special considerations for their dental appointment. Have the patient answer the following questions.

Screening Questions	**Pre-Screen**		**In-Office**	
Have you travelled outside of Canada in the past 14 days?	YES ◯	NO ◯	YES ◯	NO ◯
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	YES ◯	NO ◯	YES ◯	NO ◯
Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches (myalgias) • Nausea/vomiting, diarrhea, abdominal pain • Pink eye (conjunctivitis) • Runny nose/nasal congestion without other known cause	YES ◯	NO ◯	YES ◯	NO ◯
If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES ◯	NO ◯	YES ◯	NO ◯

- Any “yes” response must be discussed with the managing dentist immediately.
- Tell the patient when they arrive at the office, they will be asked to:
  - Sanitize their hands.
  - Answer the questions again.
  - Have their temperature taken.
  - Complete a form acknowledging the risk of COVID-19.
- Advise the patient:
  - Only patients are allowed to come to the office.
  - If possible, to wait in their car until their appointment, call the office when they arrive