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COVID-19 Screening Form

DATE: _____

PATIENT NAME: _____

1. **Have you had close contact with anyone with acute respiratory illness or travelled outside Ontario in the past 14 days?**

☐ Yes
☐ No

2. **Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of Covid-19?**

☐ Yes
☐ No

3. **Do you have any of the following symptoms?**

☐ Fever
☐ New onset 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 pain (myalgia)
☐ Nausea/vomiting, diarrhea, abdominal pain
☐ Pink eye (conjunctivitis)
☐ Runny nose/nasal congestion without other known cause
☐ none of the above

4. 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
☐ Worsening of chronic conditions
☐ None of the above