Dentistry@1881

Patient Screening Form

* Please complete pre-screen column and return form to our office prior to your appointment.

Screening Questions	Pre-Screen	In-Office
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	YES NO	YES NO
Have you ever tested positive for COVID-19?	YES NO	YES NO
Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES NO	YES NO
Do you have any of the following symptoms: • Fever • New onset of cough • Shortness of breath • 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
Are you 70 years of age or older, 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
Date:		
Initials:		

(ODA Return-to-Practice (Version 1.0)