COVID - 19 Screening Form:

We will be asking you to confirm answers to the following questions to reduce the chances of transmission of COVID-19 in our practice and the community.

If you answer "Yes" to any of the screening questions below, you will be asked to reschedule your appointment to a later date.

General Information:

Patient Name: _____Patient Age: _____

Form filled out by:__Patient_____ OR if other please specify who_____

Contact Method: Phone: _____Email:_____Other: _____

Date: _____

Screening Questions:

- Does the patient have a confirmed case of COVID-19 OR had close contact with a confirmed case of COVID-19?
  ◯ Yes ◯ No
- Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?
  ◯ Yes ◯ No

Do you have any of the following symptoms:

Fever?
◯ Yes ◯ No

Chills ?
◯ Yes ◯ No

Worsening chronic cough?
◯ Yes ◯ No

New onsent of cough?
◯ Yes ◯ No

Difficulty breathing?
◯ Yes ◯ No

Sore throat?
◯ Yes ◯ No

Shortness of breath?
◯ Yes ◯ No

Pink eye (conjunctivitis)?
◯ Yes ◯ No

Difficulty swallowing?
◯ Yes ◯ No

Decrease or loss of sense of taste or smell?
◯ Yes ◯ No

Unexplained fatigue/malaise/muscle ache (myalgais)?
◯ Yes ◯ No

Nausea/vomiting,diarrhea,abdominal pain?
◯ Yes ◯ No

Runny nose/nasal congestion without other known cause?
◯ Yes ◯ No

* If the patient is 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? ◯ Yes ◯ No ◯ N/A

** If you've answered yes to any of the questions please call (905) 727- 6453 immediately so that we can reschedule your appointment.

FOR CLINIC USE ONLY:

Date: _____ Staff Intial:_____ Forehead Temperature: _____

Patient Acknowledgement:
COVID-19 Pandemic Emergency Dental Risk

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

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious.*** For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize 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, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office.** _____ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. _____ (initial) If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT _____ Date _____

PRINT NAME _____

Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient.*