Patient Screening Form

Use this form to screen patients before their appointment and when they arrive for their appointment.
The list of symptoms may be added to or amended over time.

Staff screener: _____

Patient Name: _____ Patient age: _____

Who answered: ___ Patient ___ Other (specify) _____

Contact Method: ___ Phone ___ email ___ Other _____

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
1. Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at appointment: _____. If elevated, provide mask to patient.	YES NO	YES NO
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose?	YES NO	YES NO
3. Have you experienced a recent loss of smell or taste?	YES NO	YES NO
4. 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
5. Have you returned from travel outside of Canada in the last 14 days?	YES NO	YES NO
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES NO	YES NO
7. Is your workplace considered high risk?	YES NO	YES NO

Patient Vulnerability

8. Are you over the age of 60?	YES NO	YES NO
9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES NO	YES NO

Any "yes" response for questions 1-7 must be discussed with the managing dentist immediately.