

COVID-19 Screening Questions for Patients

Naturopathic Doctors and all other regulated health practitioners are required by the Ontario Ministry of Health & Long-Term Care to screen every patient attending an in-person appointment.

If you answer “yes” to any of the following questions, we cannot see you for an in-person appointment and you must get tested for COVID-19.

1. Have you travelled outside Canada in the last 14 days?

Yes No

2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

Yes No

3. Do you have any of the following symptoms?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • New onset of cough |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Worsening chronic cough |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Shortness of breath |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Difficulty breathing |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Sore throat |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Difficulty swallowing |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Decrease or loss of sense of taste or smell |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Chills |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Headaches |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Unexplained fatigue/malaise/muscle aches (myalgias) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Nausea/vomiting, diarrhea, abdominal pain |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Pink eye (conjunctivitis) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Runny nose or nasal congestion without other known cause |

4. If you are 70 years of age or older, are you experiencing any of the following symptoms?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Delirium |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Unexplained or increased number of falls |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Acute functional decline |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Worsening of chronic conditions |

Patient Name: _____

Signature: _____

Date: _____

COVID-19 Screening Results

- If your responses to ALL of the screening questions is NO: You have screened “Negative” and may attend your appointment.
- If your response to ANY of the screening questions is YES: You have screened “Positive” should self-isolate and get tested.