COVID-19 Patient Screening Guidance Document
As Directed by the Ministry of Health

NAME: _____ **D.O.B** _____

Have you come into close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?

YES ☐ NO ☐

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

YES ☐ NO ☐

Do you have any of the following symptoms?

YES	NO	
☐	☐	Fever
☐	☐	New onset cough
☐	☐	Worsening chronic cough
☐	☐	Shortness of breath
☐	☐	Difficulty breathing
☐	☐	Sore throat
☐	☐	Difficulty swallowing
☐	☐	Decrease or loss of sense of taste/small
☐	☐	Chills
☐	☐	Headaches
☐	☐	Unexplained fatigue/malaise/muscle aches (myalgias)
☐	☐	Nausea/vomiting
☐	☐	Diarrhea
☐	☐	Abdominal pain
☐	☐	Pink eye (conjunctivitis)
☐	☐	Runny nose/nasal congestions without other known cause.

If you are 70 years of age or older, have you experienced any of the following symptoms?

YES	NO	
☐	☐	Delirium
☐	☐	Unexplained or increased number of falls
☐	☐	Acute functional decline
☐	☐	Worsening of chronic conditions

I confirm that all of the information on this form is truthful and accurate.

_____

Signature of Client

_____

Date