COVID-19 Patient Screening Questionnaire and Consent for Contact Tracing

Please read the following information and ensure that you meet all the requirements prior to receiving treatment today. This form will be kept in your file and you will be asked to confirm that there are no changes in the answers on following visits. Only those patients who can attest to the following statements will be eligible for in-person office visits at this time.

**Do you have one of the following COVID-19 symptoms**

* **Fever (including chills or sweats)**
* **Cough (new or worsening)**
* **Shortness of breath/difficulty breathing**
* **Sore throat or difficulty swallowing (not related to a known cause/condition)**
* **Unusual headache**
* **Unusual fatigue or lack of energy**
* **New onset of muscle aches**
* **Loss of appetite**
* **Vomiting or diarrhea (more than 24 hours)**
* **Loss of sense of taste or smell**
* **Runny, stuffy or congested nose (not related to seasonal allergies or other known causes/conditions such as being outside in cold weather)**
* **Small red or purple spots on hands and/or feet in a child/young adult (if this is the only symptom, please read the information in Question #1 below)**
1. **I acknowledge that I have not been advised to self-isolate for any reason (e.g. travel, Public Health advice, public advisories)**

**Patient Initials\_\_\_\_\_\_\_\_\_**

If you are not able to attest to all the above statements, you will be asked to reschedule your appointment and contact the 811 HealthLine for further instructions.

**I hereby confirm that all the information provided above is current and correct.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psychologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_