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.

1. Do you currently or in the past 14 days have you had symptoms of COVID-19, such as:
    - Fever (or signs of a fever; including chills, sweats, muscle aches, light-headedness)
    - Cough
    - Headache
    - Sore throat
    - Painful swallowing
    - Runny nose
    - Diarrhea
    - Loss of sense of smell or taste
    - Unexplained loss of appetite
    - Small red or purple spots on your hands and/or feet
2. Have you traveled outside Newfoundland within the last 14 days?
3. Have you had close contact with individuals who have a confirmed or presumptive diagnosis of COVID-19?

I acknowledge that I am not currently, nor have I in the past 14 days, experienced any of the above COVID-19 symptoms.

Patient Initials_____

Close contact with individuals who have a confirmed or presumptive diagnosis of COVID-19 in the past 14 days and traveled outside of the Atlantic Provinces have been linked to increased risk for COVID-19 infection.

I acknowledge that I have not been in close contact with any individuals who have a confirmed or presumptive diagnosis of COVID-19 in the past 14 days.

Patient Initials_____

I acknowledge that I have not traveled outside of the Atlantic Provinces in the last 14 days, or currently have an exemption order.

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: _____

I understand and have been advised by my Psychologist that, should it become necessary due to COVID -19 circumstances, my identifying information may have to be released to relevant authorities with respect to requirements pertaining to adhering to contact tracing procedures, and I consent to the same.

Patient Signature:_____ DOB :_____ Date:_____