

Pre-Screening / Screening Questionnaire

Visitor Name and Organization:	DATE		
Contact Number:	Email:		
1. Are you experiencing any of the following symptoms:	YES	NO	
a. Fever of 38 C or higher			
b. Cough			
c. Difficulty Breathing or Shortness of Breath			
d. Malaise (severe fatigue or feeling of being generally unwell)			
2. In the last 14 days have you:	YES	NO	
a. Travelled to/from or through			
<ul style="list-style-type: none"> <li style="width: 50%;">• China <li style="width: 50%;">• Singapore <li style="width: 50%;">• Hong Kong <li style="width: 50%;">• South Korea <li style="width: 50%;">• Iran <li style="width: 50%;">• France <li style="width: 50%;">• Italy <li style="width: 50%;">• Spain <li style="width: 50%;">• Japan <li style="width: 50%;">• Germany 			
b. Been in close contact with someone who has a confirmed or probable case of COVID-19			
c. Been in close contact with a person with an acute respiratory illness who has been to the above countries within 14 days prior to their illness onset?			
Signature:	Name (please print):		
<p>If you have answered Yes to any of the above questions, please delay your attendance AND contact your healthcare provider, or Telehealth Ontario (1-866-797-0000)</p>			