

# Coronavirus COVID-19

## Leaflet 2A: SCREENING FORM FOR PATIENTS /ACCOMPANYING PERSONS

(D,H,A,T,DD,P)

<b>Name of the person screened:</b> _____  <b>Please indicate if the above name refers to the screening form for the patient or the accompanying person:</b>  <input type="checkbox"/> Patient <input type="checkbox"/> Accompanying person - Name of patient: _____	PRE-APPT.	CLINIC
	<b>Date:</b>	<b>Date:</b>
<b>1-Have you tested positive for COVID-19 in the last 21 days or have you been told that you should be tested?</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>Do you have any of the following conditions:</b>		
<b>2-Fever (over 38 °C or 100.4 °F)</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>3-New cough or worsening chronic cough</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>4-Breathing difficulties</b> (for example: shortness of breath, difficulty speaking)	<b>Yes    No</b>	<b>Yes    No</b>
<b>5-Sudden loss of smell (with or without loss of taste)</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>6-Muscle pain, headache, intense fatigue or significant loss of appetite</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>7-Sore throat</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>8-Diarrhea</b>	<b>Yes    No</b>	<b>Yes    No</b>
<b>9-Do you have a health issue that might explain the symptoms described above?</b> If so, specify: _____	<b>Yes    No</b> <b>Does not apply</b>	<b>Yes    No</b> <b>Does not apply</b>
<b>10-Have you been in close contact (at least 15 minutes at less than 2 metres) with a confirmed or suspected case of COVID-19?<sup>a</sup></b>	<b>Yes    No</b>	<b>Yes    No</b>
Signature of person who has completed the form (patient or office personnel):  Signature pre-appt.: _____                      Signature clinic: _____		
<b>THIS SECTION IS RESERVED FOR DENTAL CLINIC PERSONNEL</b>  <ul style="list-style-type: none"> <li>• <i>If the patient has answered YES to at least one of the following conditions: SUSPECTED/CONFIRMED STATUS.</i> <ul style="list-style-type: none"> <li>✓ <i>YES to question 1</i></li> <li>✓ <i>YES to at least one of the questions from 2 to 5, without any other apparent cause (question 9)</i></li> <li>✓ <i>YES to at least one of the questions from 6 to 8, without any other apparent cause (question 9);</i></li> <li>✓ <i>YES to question 10.</i></li> </ul> </li> <li>• <i>Any other answer: ASYMPTOMATIC STATUS.</i></li> </ul> <p><b>Check off the box of patient's COVID-19 status:</b>                      <input type="checkbox"/> Asymptomatic                      <input type="checkbox"/> Suspected / Confirmed</p> <p style="text-align: center;">If the patient is considered a suspected/confirmed case of COVID-19, consult the dentist before making an appointment.</p>		

<sup>a</sup> This condition excludes health workers who have cared for confirmed or suspected cases of COVID-19 wearing appropriate personal protective equipment.