

Please fill out "Patient Name, "Patient Age" and Answer the Pre-Screen questions: Check YES or NO

Staff screener: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient age: \_\_\_\_\_

Who answered:  Patient  Other (specify) \_\_\_\_\_

Contact Method:  Phone  email  Other \_\_\_\_\_

Screening Questions	Pre-Screen	In-Office
1. Do you have a fever or have felt hot or feverish anytime in the last two weeks?  Patient temperature at appointment: _____. If elevated, provide mask to patient.	CHECK YES NO	YES NO
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip?		YES NO
3. Have you experienced a recent loss of smell or taste?		YES NO
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?		YES NO
5. Have you returned from travel outside of Canada in the last 14 days?		YES NO
6. Have you returned from travel within Canada from a location known affected with COVID-19?		YES NO
7. Is your workplace considered high risk?		YES NO

**Patient Vulnerability**

8. Are you over the age of 70?		YES NO
9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?		YES NO

• Any "yes" response for questions 1-7, Please contact the office IMMEDIATELY.

**\*\*Patients Please read:**

**Day of your dental appointment.**

On arrival please stay in your vehicle. Call the office 604-792-3324. We will meet you outside the office door to: answer the screening questions again, have your temperature taken, and complete the form acknowledging the risk of COVID-19.

When entering the office, please sanitize your hands and you will be directed where to proceed.

\*\*Parents and other family members will be asked to wait outside whenever possible.

\*\*Note- Any patients showing signs of a fever or other symptoms of illness will be asked to reschedule their appointment.