Covid-19 Patient Screening survey

Please copy and paste into email with yes or no to each question. Return to: jess.f.woods91@gmail.com

1. Did the person travel outside of Canada in the past 14 days? Yes or No
2. Did the person travel outside of Ontario in the past 14 days? Yes or No
3. Did the person travel to or had visitors from any red or gray zones (Toronto, Ottawa) in the past 14 days? Yes or No
4. Has the person tested positive for COVID-19, or awaiting test results; requiring you to be isolating? Yes or No
5. Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? Yes or No
6. Have you been following the Government directives and following the Social Distancing Guidelines? Yes or No
7. Does the person have any of the following symptoms? Yes or No

   • Fever

   • New onset of cough/ worsening chronic cough

   • Shortness of breath / Difficulty breathing

   • Sore throat / Difficulty swallowing

   • Decrease / loss of sense of taste/ smell

   • Chills

   • Headaches

   • Unexplained fatigue/malaise/muscle aches (myalgias)

   • Nausea/vomiting, diarrhea, abdominal pain

   • Pink eye (conjunctivitis)

   • Runny nose or nasal congestion without other known cause

8. If the person is 70 years of age or older, are they experiencing any of the following symptoms? Yes or No

   • Delirium

   • Unexplained or increased number of falls

   • Acute functional decline

   • Worsening of chronic conditions