ALMA DENTAL CENTRE

Patient Screening Form

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.	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	YES	NO
3. Have you experienced a recent loss of smell or taste?	YES	NO	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	YES	NO
5. Have you returned from travel outside of Canada in the last 14 days?	YES	NO	YES	NO
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES	NO	YES	NO
7. Is your workplace considered high risk?	YES	NO	YES	NO

Patient Vulnerability

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

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