CHATHAM-KENT
Health Alliance

COVID-19 Outpatient/ Visitor Screening Tool

Date: _____

Name: _____

I am a Patient ☐ **I am a Visitor / Support Person ☐**

If you're a visitor, please provide the patient's name: _____

NOTE: This form has two sides. Please complete both sides.

1. **Have you OR someone you have been in close contact with travelled outside of Canada in the past 14 days?**

   YES ☐ **NO ☐**

2. **Have you had close contact with a person who has become ill?**
   (new or worse cough, shortness of breath, fever, chills, weakness, muscle aches, loss of smell or taste, headache, feeling very unwell?)

   YES ☐ **NO ☐**

3. **Have you had close contact with a confirmed case of COVID-19?**

   YES ☐ **NO ☐**

Please complete both sides of this form →

CHATHAM-KENT
Health Alliance

4. Have you been tested for COVID-19?

YES ☐ NO ☐

If yes to question #4:
Date of test (swab):_____
Test result:
☐ Positive ☐ Negative OR ☐ Awaiting results

5. Do you have ANY of the following new or unexplained symptoms:

YES ☐ NO ☐

- fever
- cough
- shortness of breath
- difficulty breathing
- sore throat
- hoarse voice
- difficulty swallowing
- loss of taste
- loss of smell
- chills
- headaches
- feeling tired
- diarrhea
- abdominal pain
- nausea/vomiting
- pink eye
- runny nose/sneezing
- nasal congestion
- feeling confused
- falling (without reason)
- difficulty doing everyday tasks
- worsening of existing condition(s)

If YES to any of the above questions
Please notify the screening checkpoint or triage nurse immediately