

## 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

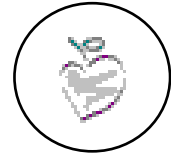
NO

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

YES

NO

**Please complete both sides of this form →**



**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

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

**If YES to any of the above questions**

**Please notify the screening checkpoint or triage nurse immediately**