Irwin DENTAL

PATIENT SCREENING FORM

Staff Screener: _____ Patient Name: _____

Patient age: _____ Who answered: ☐ Patient ☐ Other (specify)_____

Pre-Screen Contact Method: ☐ Phone ☐ e-mail ☐ Text ☐ In Person

Explain the purpose of the screening, which is to determine whether there are any special considerations for their dental appointment. Have the patient answer the following questions.

Date of Pre-Screening:_____

Screening Questions	**Pre-Screen** YES	NO
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.	☐	☐
2. Do you have any symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? Discolouration of extremities?	☐	☐
3. Have you experienced a recent loss of smell or taste?	☐	☐
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?	☐	☐
5. Have you returned from travel outside of Canada in the last 14 days?	☐	☐
6. Have you returned from travel within Canada from a location known affected with COVID-19?	☐	☐
Patient Vulnerability		
7. Do you have any of the following?: Heart Disease, hypertension, lung disease, kidney disease, diabetes, pregnancy or any auto-immune disorder?	☐	☐
8. Is there any additional information you'd like us to have?		

I Confirm that there has been no changes to the above answers since the day the pre-screening was completed. (Please sign this when you arrive to your appointment):

Patient (or Guardian) Signature:_____ Date:_____