COVID-19 Screening Checklist
(please circle patient responses)

Date: _____

First Name: _____ Last Name: _____

1. Have you been travelling outside of Canada anytime from March 1st to the present date?
    a. Yes
        i. Have you self isolated for 14 days?
            1. Yes
            2. No
    b. No
2. Are you living in the same household or been in close contact with someone who has been travelling outside of Canada anytime between March 1st to the present date?
    a. Yes
        i. Have they self isolated for 14 days
            1. Yes
            2. No
    b. No
3. Have you been in or been in contact with an individual who has been in a hospital, nursing home or long-term care facility between March 1st to the present date?
    a. Yes
    b. No
4. Have you been in contact with a presumed, or confirmed case of COVID-19?
    a. Yes
    b. No
5. Do you or anyone in your household have any cold or flu-like symptoms between March 1st to the present date?
    a. Yes
        i. Are you / they symptom free now
            1. Yes
                a. If so, how long have they been symptom free
                    i. > 14 days
                    ii. < 14 days
            2. No
    b. No

Patient Signature: _____ Date: _____

Screener Initials: _____