COVID-19 PATIENT/ESSENTIAL VISITOR SCREENING QUESTIONNAIRE

Carlisle Physiotherapy and Rehabilitation

Have you travelled outside of Canada in the past 14 days? ☐ Yes ☐ No

Have you tested positive for COVID-19 or have you had close contact with a confirmed case of COVID-19 WITHOUT wearing appropriate PPE? ☐ Yes ☐ No

Do you have any of the following symptoms? (Check those that apply)

- ☐ Fever
- ☐ New onset of cough
- ☐ Worsening of chronic cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Decrease or loss of sense of taste or smell
- ☐ Chills
- ☐ Headaches
- ☐ Unexplained fatigue/malaise/ muscle aches
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ Pink eye (conjunctivitis)
- ☐ Runny nose/nasal congestion without other known cause

If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? ☐ Yes ☐ No

If yes, please specify symptoms _____

If responses to **ALL** of the screening questions is NO: COVID screening = **Negative**
- You may attend your in-person appointment wearing appropriate mask and using proper hand hygiene and physical distancing

If responses to **ANY** of the screening questions is YES: COVID screening = **Positive**
- Your in-person appointment will be re-scheduled
- Virtual appointment will be offered
- You will be advised to self-isolate AND complete the MOH online self-assessment tool before calling your doctor or Telehealth Ontario

PATIENT AGREEMENT

☐ **I have answered the above questions truthfully to the best of my knowledge.**

Patient Name: _____ **Date:** _____

Signature: _____

+ PLEASE FAX or EMAIL THIS FORM

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