ELMVALE DENTAL CARE

Patient Screening Form

The intended use of this form is to screen patients before their appointment (over the phone by reception team) and when they arrive for their appointment (in person by reception team)

Patient Name: _____ Patient DOB: _____
Who answered: ____ Patient ___ Other (specify) _____
Scheduled Appointment Date: _____

Screening Questions:

Part 1a) General Medical History Questions: PRE-SCREEN (Screener:_____ Date:_____)

i. Have you experienced any changes in your health history since your last visit? _____
ii. Have your medications changed? Are you on any new medications? _____
iii. Have you seen your family doctor or been to the hospital since your last visit? If so, for what reason:
_____
iv. Please confirm your existing allergies (if any). Do you have any new allergies? _____

*Comments:*_____
_____

Part 1b) Patient Vulnerability: PRE-SCREEN (Screener:_____ Date:_____)

i. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorder? _____
ii. Are you over 70 and experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, worsening of chronic conditions?

*Comments:*_____
_____

Part 2) COVID-19 Screening Questions	PRE-SCREEN DATE: _____ (initial) _____	IN-OFFICE DATE: _____ (initial) _____
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	YES NO	YES NO
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	YES NO	YES NO
Do you have any of the following unusual symptoms? Fever, new onset of cough, worsening of chronic cough, shortness of breath, difficulty breathing, increased soreness of throat, difficulty swallowing, decrease or loss of sense of taste or smell, chills, worsening headaches, unexplained fatigue/malaise/muscle aches, nausea/vomiting, diarrhea, abdominal pain, pink eye, runny nose/nasal congestion without other known cause (i.e. allergies) **Comments:**	YES NO	YES NO
Temperature Reading upon entry	-	
OVERALL STATUS (COVID+/COVID-) Responses to all questions from Part 1bii) and Part 2) must be NO in order to be COVID-/any YES those questions is COVID+ (Ministry of Health, v3.0 May 17, 2020 screening guidance)		

Part 3) Post-Op Call Status:

Date: _____ Screener: _____ Patient Comments re symptoms in last 10-14 days:
_____
_____