**COVID-19 Screening Form**

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| Q1: Do you have a concern for a potential COVID-19 infection for the person? | yes | No |
| Q2: Did the person have close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days? |  |  |
| Q3: Does the person have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19? |  |  |
| Q4: Do You have any of the following symptoms?   * Fever * New onset of cough * Worsening 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 (myalgias) * Nausea/vomiting, diarrhea, abdominal pain * Pink eye (conjunctivitis) * Runny nose/nasal congestion without other known cause |  |  |
| Q5: If you are 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? |  |  |

First & last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: