LOUGHEED DENTAL CLINIC

Patient Screening Form

Patient Name: Date:

Patient Screening

1. Do you have a fever or have felt hot or feverish anytime in the last two weeks?	YES ☐ NO ☐
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip?	YES ☐ NO ☐
3. Have you experienced a recent loss of smell or taste?	YES ☐ NO ☐
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?	YES ☐ NO ☐
5. Have you returned from travel outside of Canada in the last 14 days?	YES ☐ NO ☐
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES ☐ NO ☐
7. Is your workplace considered high risk?	YES ☐ NO ☐

Patient Vulnerability

8. Are you over the age of 70?	YES ☐ NO ☐
9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES ☐ NO ☐