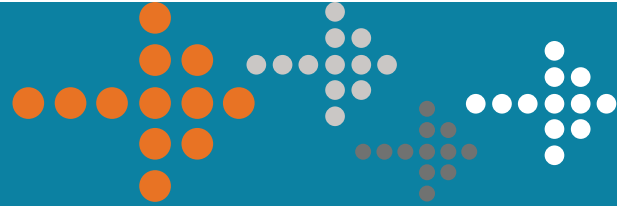




# COVID-19 Screening Tool



Name (Print): \_\_\_\_\_ Department: \_\_\_\_\_

In-Person (Yes/No): \_\_\_\_\_ Telephone Call (Yes/No): \_\_\_\_\_

Date: \_\_\_\_\_ Time In: \_\_\_\_\_

**IF YOU OR ANY MEMBERS OF YOUR HOUSEHOLD HAVE TRAVELED OUTSIDE OF ONTARIO IN THE PAST 14 DAYS YOU ARE NOT PERMITTED TO ENTER THE \_\_\_\_\_ FACILITY.**

## SECTION A: Are you experiencing any of the following symptoms with unknown cause?

- |                                                           |                                                          |                                                                                                                                                                                                                     |                                                          |
|-----------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| • Fever                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Difficulty breathing                                                                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • New onset of cough                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Loss of taste or smell                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Worsening chronic cough                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Chills                                                                                                                                                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Sore throat                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you had contact with any person with, or under investigation for, COVID-19 in the last 14 days?                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Headaches                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you or anyone from your household travelled outside of Ontario?                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Unexplained fatigue/<br>malaise/muscle aches (myalgias) | <input type="checkbox"/> Yes <input type="checkbox"/> No | • If the person is 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Nausea/vomiting, diarrhea, abdominal pain               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                     |                                                          |
| • Pink eye (conjunctivitis)                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                     |                                                          |
| • Runny nose/nasal congestion without other known cause   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                     |                                                          |
| • Shortness of breath                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                     |                                                          |

## OFFICE USE ONLY

### In-person, the person being screened was:

- Unfit to work and sent home  Yes  No
- Sent back to work  Yes  No
- Referred to a doctor or Public Health with benefit forms (if applicable)  Yes  No

### On the telephone, the person being screened was:

- Instructed to stay or remain at home  Yes  No
- Referred to go see a doctor or Public Health and sent benefit forms (if applicable)  Yes  No
- Advised they can come to work  Yes  No

## SECTION B:

If the person being screened was directed to self-quarantine for 14 days post-travel/exposure risk, indicate the start date: dd / mm / yy and the end date: dd / mm / yy.

Date Quarantine was completed: dd / mm / yy.





**IF YOU ARE BEING REFERRED TO PUBLIC HEALTH FROM THIS SCREENING, CONTACT THE PUBLIC HEALTH DEPARTMENT FOR YOUR AREA OR TELEHEALTH ONTARIO AT 1-800-797-0000 (FOR THOSE IN ONTARIO).**

Facility Representative or H&S Designate: \_\_\_\_\_ Date: dd / mm / yy.

Please contact your office/clinic H&S Designate for assistance.

Reference: Centers for Disease Control and Prevention website <https://www.cdc.gov/>

Version Date: March 15, 2020 For further information on COVID-19, refer to the

Public Health Agency of Canada <https://www.canada.ca/coronavirus>

June 2, 2020

**Government of Ontario Self Assessment: [covid-19.ontario.ca/self-assessment/](https://covid-19.ontario.ca/self-assessment/)**

**Public Health Ontario COVID-19 Information: 1-877-604-4567**

**Public Services Health and Safety Association: 1-877-250-7444**



Ontario  
Chiropractic  
Association