Screening Questions

1. Do you have any of the following **new** or **worsening** symptoms or signs?

Fever of 37.8 or greater	☐ Yes	☐ No
New or worsening cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Runny nose, sneezing or nasal congestion without other known cause (allergies)	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Decrease or loss of sense of taste or smell	☐ Yes	☐ No
Nausea/vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Unexplained fatigue/malaise/muscle aches (myalgias)	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Pink Eye (Conjunctivitis)	☐ Yes	☐ No

2. Have you travelled outside of Ontario/Canada or had close contact with anyone that has travelled outside Ontario/Canada in the past 14 days?

☐ Yes ☐ No

3. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?

☐ Yes - go to question 4 ☐ No - screening complete

4. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19?

☐ Yes ☐ No

5. For patients **70 years of age or older**, are you experiencing any of the following symptoms:

Delirium	☐ Yes	☐ No
Unexplained or increased number of falls	☐ Yes	☐ No
Acute functional decline	☐ Yes	☐ No
Worsening of chronic conditions	☐ Yes	☐ No