FRASER VALLEY
ANESTHESIA FOR DENTISTS

COVID-19 Patient Screening

Patient section must be completed and returned to our office 1-3 business days prior to your appointment. To protect the health and safety of all patients and staff, **your appointment will be postponed in the event we do not receive this form on time.** Any changes to your health status must be reported to our office prior to arriving for your appointment. **This screening is applicable to the patient as well as responsible accompanying adult if applicable.**

Patient Section Name:___________________________ Date of Birth:____________________________

Do you have a risk factor for COVID-19? In the last 14 days have you

Returned from travel outside of Canada?	☐Yes	☐No	When? Date:____________________
Been in close contact with anyone diagnosed with lab confirmed COVID-19?	Yes	☐No	When? Date:____________________
Lived or worked in a setting that is part of a COVID-19 outbreak?	Yes	No	When? Date:____________________
Been advised to self-isolate or quarantine at home by public health?	Yes	☐No	When? Date:____________________

Fever	☐ **Yes** ☐ **No**	**Sore throat or painful swallowing**	☐ **Yes** ☐ **No**
Cough	☐ **Yes** ☐ **No**	**Loss of sense of smell**	☐ **Yes** ☐ **No**
Shortness of breath	☐ **Yes** ☐ **No**	**Loss of appetite**	☐ **Yes** ☐ **No**
Diarrhea	☐ **Yes** ☐ **No**	**Chills**	☐ **Yes** ☐ **No**
Nausea and/or vomiting	☐ **Yes** ☐ **No**	**Muscle aches**	☐ **Yes** ☐ **No**
Headache	☐ **Yes** ☐ **No**	**Fatigue**	☐ **Yes** ☐ **No**
Runny nose/nasal congestion	☐ **Yes** ☐ **No**		

I _______________________________ have completed the above information to the best of my ability and verify it's accuracy.

Signature of Acknowledgment **Date**

____ _________________________________

Office Evaluation **Date/ Time of Appointment** _____________________**Temperature:**_________________

Fever	☐ **Yes** ☐ **No**	**Sore throat or painful swallowing**	☐ **Yes** ☐ **No**
Cough	☐ **Yes** ☐ **No**	**Loss of sense of smell**	☐ **Yes** ☐ **No**
Shortness of breath	☐ **Yes** ☐ **No**	**Loss of appetite**	☐ **Yes** ☐ **No**
Diarrhea	☐ **Yes** ☐ **No**	**Chills**	☐ **Yes** ☐ **No**
Nausea and/or vomiting	☐ **Yes** ☐ **No**	**Muscle aches**	☐ **Yes** ☐ **No**
Headache	☐ **Yes** ☐ **No**	**Fatigue**	☐ **Yes** ☐ **No**
Runny nose/nasal congestion	☐ **Yes** ☐ **No**		

Screened by:___________________________________ **Signature:**_______________________________