Covid-19 Patient Assessment Form

TO BE FILLED OUT WITHIN 24HRS OF YOUR APPOINTMENT

(IF ANSWER IS YES TO ANY QUESTIONS BELOW, IT WILL BE REBOOKED WITH **NO** FEE TO PATIENT)

DATE: _____ **Name** ***(if you are not our patient, please include patient name*** *on this form:*_____

Healthcare #: _____ **Date of birth:**_____

1. Do you HAVE or HAD any Covid-19 symptoms in the past 14 days such as:

Difficulty breathing	YES	NO
Fever	YES	NO
New/change in cough	YES	NO
New loss of taste/smell	YES	NO
Sore throat	YES	NO
Persistent pain/pressure in chest	YES	NO
Congestion/runny nose/cold symptoms	YES	NO

2. Have you had ANY flulike symptoms in the past 14 days such as chills, fatigue, muscle aches, vomiting, headache, nausea or diarrhea?

YES NO

3. Have you or a family member been asked to self isolate in the past 14 days?

YES NO

4. Have you been in close contact with someone who has been diagnosed with Covid-19 in the past 14 days or is awaiting diagnosis?

YES NO

5. Have you travelled out of province in the past 14 days or been in contact with someone who has?

YES NO

6. Are you awaiting results of a lab test for Covid-19?

YES NO

7. Have you or an immediate family member tested positive for Covid-19? If so, when?

YES NO Date, if yes:_____

Patient Signature: _____