



Health Record #: \_\_\_\_\_ Complete or place barcoded patient label here  
 Patient Name: *(Print first, last)* \_\_\_\_\_  
 DOB: dd / mm / yy Age: \_\_\_\_\_  Female  Male  
 OHIP #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Account #: \_\_\_\_\_ Date of Admission: dd / mm / yy

**COVID-19 Patient Screening Tool**

Date: dd / mm / yy

Name: *(print first, last)* \_\_\_\_\_ Signature: \_\_\_\_\_

This form **MUST** be completed the day of your visit. It will be used at the screening entrance to provide you with priority access and given to the clinical team when you arrive for your procedure or test.

1. Have you been tested for COVID-19?  Yes  No

If **YES** please complete section below:

Date Tested: dd / mm / yy Results:  Negative  Positive  Unknown

Test Location: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

2. Have you travelled or had close contact with anyone that has travelled in the last 14 days?  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_

3. In the last 24 hours have you had any of the following symptoms?

- |   |  |   |  |
|---|--|---|--|
| Fever   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty swallowing                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| New onset of cough                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Decreased/loss of sense of taste or smell | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Worsening chronic cough                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea/vomiting, diarrhea, abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty breathing                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexplained fatigue/malaise/muscle aches  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath                                   | <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 | Headache                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Runny nose/nasal congestion without other known cause | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pink eye (conjunctivitis)                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered **YES** to any of the symptoms listed above, please provide details below:

\_\_\_\_\_  
 \_\_\_\_\_

4. Have you had contact with someone who has COVID-19 or has been tested/swabbed for COVID-19?  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Day of Procedure/Appointment**

1. Upon arrival at Southlake, **you must pre-register before entering the building**, please call: **905-895-4521**; after the recording, please enter **2868#** and then press **option 1** (If you don't have a cell phone, please speak to the staff at the entrance).
2. Please have your health card ready and be prepared to confirm your name, date of birth, address, family doctor's name.
3. Once completed, please proceed to the Medical Arts Building Entrance with this Screening Tool.
4. Please arrive wearing a mask if you have one.

