SCREENING: COVID-19

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Screening will be performed verbally upon booking an in-clinic appointment with us and upon each entry to our clinic. Below you are confirming you understand the screening, and that each time we ask you verbally these questions; that you will answer truthfully. You are also confirming that you will notify us should your answers change at any time. A positive screening will result in the cancellation of any ongoing in-clinic sessions and your need to self isolate. This does not preclude you from telerehabilitation sessions. Our clinicians and staff members are also required to screen negative prior to and at the beginning of every shift. Signing digitally below and the return of this form is your legal consent. ☐

Patients/Workers are not permitted to enter the clinic: if yes to any of the first four questions or no to the 5th question & must self quarantine for 14 days

Screening Questions:

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

Fever	◯ Yes	◯ No
New onset of a cough	◯ Yes	◯ No
Worsening Chronic Cough	◯ Yes	◯ No
Shortness of breath	◯ Yes	◯ No
Difficulty Breathing	◯ Yes	◯ No
Sore throat	◯ Yes	◯ No
Runny nose, sneezing or nasal congestion (in the absence of underlying reason for symptoms such as seasonal allergies and post-nasal drip)	◯ Yes	◯ No
Hoarse voice	◯ Yes	◯ No
Difficulty swallowing	◯ Yes	◯ No
New loss or decrease in 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 Canada or had close contact with anyone that has travelled outside Canada in the past 14 days? ◯ Yes ◯ No

3. You are over the age of 70 years and you are experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? ◯ Yes ◯ No ◯ N/A

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? ◯ Yes – go to question #5 ◯ No – screening complete

5. 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 ◯ N/A

Your Legal Name (Mandatory) _____ Your Email Address (Mandatory) _____ Date _____

Once you have filled out this form please save it to your computer then email it, along with your other relevant filled out forms, to **info@mariposaphysio.ca**

Adapted and updated from Ontario Ministry of Health – May 29, 2020