PATIENT SCREENING FORM

Use this form to screen patients before their appointment and when they arrive for their appointment.

Staff screener: _____

Patient Name: _____Patient age: _____

Who answered: _____ Patient _____ Other (specify): _____

Contact Method: _____ Phone _____ email _____

Other:

Identify yourself and explain the purpose of the call, which is to determine whether there are any special considerations for their dental appointment. Have the patient answer the following questions.

Screening Questions	Pre-Screen		In-Office	
Have you travelled outside of Canada in the past 14 days?	YES ◯	NO ◯	YES ◯	NO ◯
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	YES ◯	NO ◯	YES ◯	NO ◯
Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches (myalgias) • Nausea/vomiting, diarrhea, abdominal pain • Pink eye (conjunctivitis) • Runny nose/nasal congestion without other known cause	YES ◯	NO ◯	YES ◯	NO ◯
If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES ◯	NO ◯	YES ◯	NO ◯

- Any “yes” response must be discussed with the managing dentist immediately.
- Tell the patient when they arrive at the office, they will be asked to:
  - Sanitize their hands.
  - Answer the questions again.
  - Have their temperature taken.
  - Complete a form acknowledging the risk of COVID-19.
- Advise the patient:
  - Only patients are allowed to come to the office.
  - If possible, to wait in their car until their appointment, call the office when they arrive

PATIENT ACKNOWLEDGEMENT: COVID-19 PANDEMIC DENTAL RISK

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus **may not show symptoms and still be contagious**. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and **I recognize it is not possible to maintain this distance while receiving dental treatment**. _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office**. _____ (initial)

I agree to complete a COVID-19 screening questionnaire as required by the Ministry of Health. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. _____ (initial) If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN Date

Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient.*