Lakeshore West Dental

Patient Screening Form (EMAIL form)

Patient Name: _____ Patient age: _____

Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at date of appointment: _____.	YES	NO
Do you have any of these symptoms: New onset of cough? Worsening chronic cough? Shortness of breath? Difficulty breathing? Sore throat? Difficulty swallowing: Chills? Headaches? Unexplained fatigue/malaise/muscle aches? Nausea/vomiting, diarrhea, abdominal pain? Pink eye? Runny nose/nasal congestion without other known cause?	YES	NO
Have you experienced a recent loss of smell or taste?	YES	NO
Have you been in contact with anyone with acute respiratory illness or traveled outside of Canada in the past 14 days?	YES	NO
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE (***personal protective equipment***)?	YES	NO
Are you over the age of 70 years of age or older, experiencing any of the following symptoms: delirium unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES	NO
Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES	NO

Any "yes" response must be discussed with the managing dentist immediately.

When arriving at our office you will be required to:

- Wear a mask.
- Sanitize your hands.
- Answer the questions again.
- Have your temperature taken.
- Complete a form acknowledging the risk of COVID-19

PLEASE NOTE THAT ONLY PATIENTS ARE ALLOWED TO COME TO THE OFFICE. FOR PATIENTS THAT ARE MINORS, ONLY ONE PARENT/GUARDIAN IS ALLOWED TO ACCOMPANY THE CHILD.

WHEN YOU ARRIVE AT OUR OFFICE PLEASE WAIT IN YOUR CAR UNTIL YOUR APPOINTMENT. PLEASE CALL OUR OFFICE FROM YOUR CAR AND WE WILL CALL YOU BACK ONCE WHEN WE ARE READY TO HAVE YOU COME INTO OUR OFFICE FOR APPROPRIATE SCREENING.

_____

SIGNATURE of patient and/or guardian DATE

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