Lakeshore West Dental

Patient Screening Form **(Date Effective: August 26, 2021)**

Patient Name: _________________________________ Patient age: __________ Patient temperature: _________

1. Do you have any of the following symptoms? YES ☐ NO ☐

   - Fever and/or chills
   - New onset of cough or worsening chronic cough
   - Shortness of breath
   - Decrease or loss of sense of taste or smell
   - If adult >18 years of age: unexplained fatigue/lethargy/malaise/muscle aches(myalgias)
   - If child <18 years of age: nausea/vomiting, diarrhea

2. Have you tested positive for COVID-19 in the past 10 days or have you been told you should be self-isolating.

   YES ☐ NO ☐

3. Have you received your final (or second) vaccination dose more than 14 days ago? YES ☐ NO ☐

   (A fully immunized individual is defined as any individual >14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series (i.e. Johnson and Johnson)

ANSWER ONLY IF YOU ANSWERED NO TO ABOVE QUESTION (3)

4. Have you traveled outside Canada in the past 14 days?

   YES ☐ NO ☐

5. Have you been in close contact with an individual that has been confirmed COVID-19 Positive without the proper PPE's?

   YES ☐ NO ☐

______________________________________ ________________________

SIGNATURE of patient and/or guardian DATE