MELDRUM orthodontics

COVID-19 Patient Screening

Patient Name: Date of Birth:

Name of Person Answering Questions (if not patient):

Relationship to Patient:

Email address: Phone number:

Please read and answer the following Ministry of Health Questions:

Questions	**YES**	**No**
1. Did you have close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	◯	◯
2. Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	◯	◯
3. 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	◯	◯
4. 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 - Worsening of chronic conditions	◯	◯

Signature/Type Name of Consenting Party:

Date:

**By typing your name into the signature field above, you agree that you are signing this document electronically and that your electronic signature is the legal equivalent of your manual signature on this document. You are confirming that the above information is true and accurate.*