SUNRISE VILLAGE DENTAL CENTRE

COVID-19
Patient Screening Form

Please fill out this form before your visit.

Date (mm/dd/yyyy): _____

Staff screener: _____

Name (First/Last): _____ Patient age: _____

Who answered: ☐ Patient ☐ Other (Specify): _____

Contact Method: ☐ Phone ☐ Email ☐ Other: _____

Contact Info: Mobile: _____ Email: _____

Screening Questions

	Pre-Screen		In-Office	
1. Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at appointment: _____.___°C. If elevated, provide mask to patient.	YES ☐	NO ☐	YES ☐	NO ☐
2. Do you have any of these symptoms: Dry cough, shortness of breath, difficulty breathing, or a sore throat?	YES ☐	NO ☐	YES ☐	NO ☐
3. Have you experienced a recent loss of smell or taste?	YES ☐	NO ☐	YES ☐	NO ☐
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES ☐	NO ☐	YES ☐	NO ☐
5. Have you returned from travel outside of Canada in the last 14 days?	YES ☐	NO ☐	YES ☐	NO ☐
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES ☐	NO ☐	YES ☐	NO ☐
7. Is your workplace considered high risk for COVID-19?	YES ☐	NO ☐	YES ☐	NO ☐

Patient Vulnerability

8. Are you over the age of 70?	YES ☐	NO ☐	YES ☐	NO ☐
9. Do you have any of the following: heart disease, lung disease, kidney disease, diabetes, any auto-immune disorder, undergoing chemo and/or radiation therapy?	YES ☐	NO ☐	YES ☐	NO ☐

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Patient Acknowledgement Form: COVID-19 Pandemic Emergency 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 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, it is recommended to stay home and avoid close contact with other people when at all possible.	*(Initials)*
I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 metres (6 feet) and I recognize it is ***not possible to maintain this distance while receiving dental treatment.***	*(Initials)*
I understand that it is possible that oral surgery/dental procedures can create water and/or blood spray, which may be one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus.	*(Initials)*
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 AND SPREADING the novel coronavirus simply by being in the dental office.***	*(Initials)*
I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache.	*(Initials)*
I confirm that I have not tested positive for COVID-19.	*(Initials)*
I confirm that I am not waiting for the results of a test for COVID-19.	*(Initials)*
I confirm that this is not currently a period where I'm required to self-isolate for 14 days.	*(Initials)*
I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.	*(Initials)*

Signature of Patient: _____ Date: _____