Patient Screening Form

SCREENING QUESTIONS	Pre-Screen
Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario 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?	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
Are you 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

If any *"YES"* Please call the office immediately as you will not be able to be seen.

Please **TEXT Lakeshore 226-787-2833 or LaSalle 226-787-2479** upon arrival for instructions on how to enter the office.