MANOTICK MEDICAL CENTRE
VISITOR/PATIENT COVID-19 SCREENING FORM

Please complete the following form <u>prior</u> to entering the clinic. All patients/ visitors MUST wear a mask that covers the mouth, nose and chin areas.

I am a: Visitor ___ OR Patient ____ Today's date: _______________ (MM/DD/YY)

Name: _________________________ _____________________________________
(First Name) (Last Name)

QUESTIONS

1. In the past 14 days, have you travelled outside Canada? ___ Yes ___No

2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? ___ Yes ___No

3. Are you **<u>CURRENTLY</u>** waiting for a COVID-19 test result, or, have you been advised by a medical professional/public health unit that you should be isolating (Staying at home)? ____ Yes ____ No

4. Have you been in close physical contact with someone who is currently sick with symptoms associated with COVID-19? ____ Yes ____ No

5. Do you have any **<u>ONE</u>** of the following symptoms? ____ Yes ____No

   - o Fever
   - o New onset of cough
   - o Worsening chronic cough
   - o Shortness of breath
   - o Difficulty breathing
   - o Sore throat
   - o Hoarse Voice
   - o Difficulty swallowing
   - o Decrease or loss of sense of taste/smell
   - o Chills
   - o Headaches
   - o Unexplained fatigue/malaise/muscle aches
   - o Diarrhea
   - o Abdominal pain
   - o Nausea/vomiting
   - o Pink eye (conjunctivitis)
   - o Runny nose/sneezing without other known cause
   - o Nasal congestion without other known cause

<u>If NO</u> to **<u>ALL</u>** questions above, you have **<u>PASSED</u>** and are permitted to enter the clinic.

<u>If YES</u> to **ANY** of the above questions, you are **<u>NOT</u>** permitted to enter the clinic. Please call us directly at 613-692-2571 for further instructions.

Should you experience **<u>ANY</u>** symptoms while in clinic you **<u>MUST</u>** immediately report this to a member of the MMC Team.

Patient/Visitor Signature: ____

REVISED: JULY 2021