COVID-19 Patient Pre-Screening

Answer the following questions	Pre-Screen
1) Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	N Y
2) Are you/they having shortness of breath or other difficulties breathing?	N Y
3) Do you/they have a cough?	N Y
4) Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	N Y
5) Have you/they experienced recent loss of taste or smell?	N Y
6) Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	N Y
7) Is your/their age over 60?	N Y
8) Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	N Y
9) Have you/they traveled in the past 14 days to any regions affected by COVID-19? *(as relevant to your location)*	N Y
Risk Level:	

First & Last Name

Email Address

Signature

X

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