Name of the person screened: _____ **Please indicate if the name above matches the patient or attendant screening form:** ☐ Patient ☐ Support person - Patient name:_____	**PRE-APPOINTMENT** **Date:**	**CLINICAL** **Date:**
1-Are you currently in isolation for a positive COVID-19 test result?	☐ Yes ☐ No	☐ Yes ☐ No
2-Have you received a recommendation to take a screening test or are you awaiting the result?	☐ Yes ☐ No	☐ Yes ☐ No
3- Have you received the instruction to place yourself in administrative segregation (e.g .: returning from a trip abroad for less than 14 days, contact of a case confirmed of COVID-19)?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have the following symptoms:		
4-Do you have the sensation of being feverish, having chills like during a flu, or a fever measured with a temperature taken by mouth equal to or greater than 38 ° C (100.4 ° F) or above 37.8 ° C or 100.00 F for the elderly?	☐ Yes ☐ No	☐ Yes ☐ No
5-Have you recently had a new or worsened cough?	☐ Yes ☐ No	☐ Yes ☐ No
6-Do you have difficulty breathing?	☐ Yes ☐ No	☐ Yes ☐ No
7-Are you out of breath?	☐ Yes ☐ No	☐ Yes ☐ No
8-Do you have a sudden loss of smell (without nasal congestion) with or without loss of taste?	☐ Yes ☐ No	☐ Yes ☐ No
9- Do you have a sore throat?	☐ Yes ☐ No	☐ Yes ☐ No
10- Do you have a runny nose or nasal congestion?	☐ Yes ☐ No	☐ Yes ☐ No
11- Do you have at least 2 of the following symptoms? • Headache • Intense fatigue • Muscle pain (not related to physical exertion) • Significant loss of appetite • Nausea or vomiting • Abdominal pain • Diarrhea	☐ Yes ☐ No	☐ Yes ☐ No
12-Do you have a known health condition that could explain the symptoms reported above? If yes, specify: _____	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable

Signature of the person who completed the form (patient or office staff):
Signature pre-appointment:_____ **Signature clinic:**_____

THIS SECTION IS RESERVED FOR DENTAL CLINIC STAFF

- *If the person answered YES to at least one of the following conditions: SUSPECTED / CONFIRMED STATUS*
  - ✓ *YES at least one of questions 1 to 3*
  - ✓ *YES at least one of questions 4 to 11, with no other apparent causes (question 12)*
- *Any other response: NON-AT-RISK STATUS*

Check the box corresponding to the person's COVID-19 status: ☐ Suspected / Confirmed ☐ Not at risk

If the person is considered to be suspected / confirmed COVID-19, consult the dentist before making an appointment