|  |  |
| --- | --- |
| Name of Patient:  |  |
| Date of Birth: |  |
| Date Form Completed: |  |

|  |  |  |
| --- | --- | --- |
| **Pre-Screening Questions** | **Yes** | **No** |
| 1. 1 Have you travelled to any high risks countries in the last few weeks?
 | ☐ | ☐ |
| 1. Have you had any signs of a prolonged coughs or temperature in the last few days?
 | ☐ | ☐ |
| 1. Have you been in contact with anyone who may have the corona virus?
 | ☐ | ☐ |
| 1. Have you experienced cold or flu symptoms (cough, runny nose, fever or sore throat, but not seasonal allergies) in the last 3 days?
 | ☐ | ☐ |
| 1. Do you **CURRENTLY** have any cold or flu symptoms (cough, runny nose, fever, or sore throat, but not seasonal allergies)?
 | ☐ | ☐ |

If the response is **YES** to any of the above questions, you will **not be permitted** access to the dental practice.

**\* Close contact:**

1. Providing care for the individual, including health care workers, family members or other caregivers, or who had other similar close physical contact with the person without consistent and appropriate use of personal protective equipment OR
2. Living with or otherwise had close prolonged contact (within 2 meters) with the person while the person was infectious with any respiratory illness OR

Having direct contact with infectious bodily fluids of the person (ex: was coughed or sneezed on) while not wearing recommended personal protective equipment

# On-Site Assessment (Part B – Practice Use Only )

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Body Temp. ° C |  |  |
| 1. Based on confirmation of responses to the above Pre-Access questions and the individual’s body temperature, are they cleared  | ☐ | ☐ |