COVID-19 (Coronavirus) Screening Questionnaire

At **Del Vecchio Dentistry**, the health and safety of our patients and staff has always been our top priority. To ensure we are providing the safest environment possible to deliver dental care, we kindly ask you to please complete this brief questionnaire prior to your appointment. This has been mandated by the Royal College of Dental Surgeons of Ontario for everyone's safety. We appreciate your help and understanding with this measure.

If the answer to any of the following questions is **YES**, please inform our reception staff **IMMEDIATELY** for further instruction. Thank you.

Patient's Name:	**PRE-APPOINTMENT**	**IN-OFFICE**
Screening Date	_____	_____
Did the person have close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?	YES ☐ NO ☐	YES ☐ NO ☐
Does the person have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	YES ☐ NO ☐	YES ☐ NO ☐
Does the person 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 ☐	YES ☐ NO ☐
If the person is 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES ☐ NO ☐	YES ☐ NO ☐
Is the person's temperature 37.8 degrees or higher?	YES ☐ NO ☐	YES ☐ NO ☐

COVID-19 Screening Results

If response to **ALL** of the screening questions is **NO**:	***COVID Screen Negative***
If response to **ANY** of the screening questions is **YES**:	***COVID Screen Positive***

Patient's Name: _____

Date: _____

Signature: _____

Note: Please feel free to save this file and email it to us at **info@delvecchiodentistry.com** and as you arrive at the office we will ask you to sign it . Alternatively, you can print this document and bring a signed copy to your appointment.

Patient Acknowledgement:
COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious.*** For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment.** _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office. _____** (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. _____ (initial) If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT _____ Date _____

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Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient*.