Date: _____

Maple Gate Medical Building
2200 Rutherford Road, Suite 202
Vaughan, Ontario L4K 5V2
905-303-4327

## COVID-19 Screening

We are committed to ensuring the safety and wellbeing of our staff and patients during this pandemic. Please answer the questions below and submit it WITHIN 24 HOURS of your booked appointment.

**1 Patient Contact Information**

First Name: _____ Last Name: _____

Email Address: _____

2. Have you traveled or had close contact with someone who has travelled outside of Ontario over the past 14 days? ☐ Yes ☒ No

3. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? ☐ Yes ☒ No

| **4.** Have you experienced any of the following symptoms over the past 14 days: (check all that apply) | | | | | |
|---|---|---|---|---|---|
| ☐ | Cough | ☐ | Shortness of breath or difficulty breathing | ☐ | Fever |
| ☐ | Difficulty swallowing | ☐ | Chills | ☐ | Repeated shaking with chills |
| ☐ | Muscle pain/fatigue | ☐ | Headache | ☐ | Sore throat |
| ☐ | Nausea/vomiting, diarrhea, abdominal pain | ☐ | Pink eye (conjunctivitis) | ☐ | Runny nose/nasal congestion without other known cause |
| ☐ | New loss of taste or smell | ☐ | **None of the Above** | | |

5. Are you a healthcare worker? ☐ Yes ☒ No

6. If you are a healthcare worker do you work directly with patients who are confirmed COVID-19 positive? ☐ Yes ☐ No ☒ I am not a healthcare worker

By submitting this form, you certify that all information is true and correct to the best of your knowledge.