COVID-19 PATIENT SCREENING FORM

Instruction for use: Use one form for each patient appointment. Ask the patient these questions at time appointment is made or with appointment reminder, and again no more than two days before appointment.

Patient/Parent/Guardian Names:______________________________

Screening Questions	Date:________ Initials:________	Date:________ Initials:________	Action
Are you experiencing shortness of breath or having trouble breathing?	☐ No ☐ Yes	☐ No ☐ Yes	Reschedule appointment after symptoms gone or patient has proof no CoViD-19.
Do you have a dry cough?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a fever or above-normal temperature (>100.4 F)?	☐ No ☐ Yes	☐ No ☐ Yes	If yes to any two symptoms, Reschedule appointment after symptoms gone or patient has proof no CoViD-19.
Do you have a runny nose?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a sore throat?	☐ No ☐ Yes	☐ No ☐ Yes	
Are you experiencing chills or repeated shaking with chills?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have unexplained muscle pain?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have a headache?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you experienced any of the above symptoms in past 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	Do not see patient unless it has been >7 days since symptoms first appeared and 3 days of no fever.
Have you been in contact with someone who has tested positve for COViD-19 in past 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	If yes, schedule 14+ days after last contact.
Have you been tested for CoViD-19 in past 14 days? If yes, what were the results?	☐ No ☐ Yes ☐+ ☐? ☐-	☐ No ☐ Yes ☐+ ☐? ☐-	If positive, schedule >7 days after symptoms first appeared and 3 days of no fever.
Have you traveled >100 miles from your home in past 14 days?	☐ No ☐ Yes	☐ No ☐ Yes	Determine risk based on location and behavior (distancing/mask/hygiene)

I agree to notify the dental practice if within 14 days I become ill with CoViD-19 symptoms or test positive for CoViD-19. I understand the dental practice has a legal and ethical obligation to inform me if staff person I had contact with tested positive for CoViD-19 within 14 days.

Patient/Parent/Guardian Signature: ______________________________ Date: __________