



**Screening questions prior to attending appointment or staff returning to office:**

- 1) Have you travelled outside of Canada within the past 14 days?
- 2) Have you recently been tested for COVID-19 due to symptoms and are currently awaiting test results?
- 3) Have you been in close contact with someone who is confirmed to currently have COVID-19 within the past 14 days?
- 4) Are you currently, or have you in the past 24-hours, been feeling unwell OR do you have any new unexplained symptoms related to COVID-19?  
Symptoms could include:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <input type="radio"/> Fever (feeling hot to touch, a temperature of 37.8 or higher)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> New or worsening cough (continuous, more than usual)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Barking cough or making a whistling when breathing (croup)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Shortness of breath, difficulty breathing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Sore throat   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Difficulty swallowing   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Lost sense of taste or smell  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Chills  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Headache that is unusual or long-lasting  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Muscle aches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Nausea/vomiting, diarrhea, abdominal pain   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Pink eye (conjunctivitis)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Runny, stuffy or congested nose (not related to seasonal allergies or other known causes or conditions) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Extreme tiredness that is unusual (fatigue, lack of energy)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Sluggishness or lack of appetite (especially in young children)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If you should answer YES to any of these questions, please do not enter this facility.**

**You are required to self-isolate and contact your treating physician, the nearest assessment centre OR Telehealth Ontario at 1-866-797-000.**

For a list of assessment centres, visit [TBDHU.COM/testinginfo](http://TBDHU.COM/testinginfo).