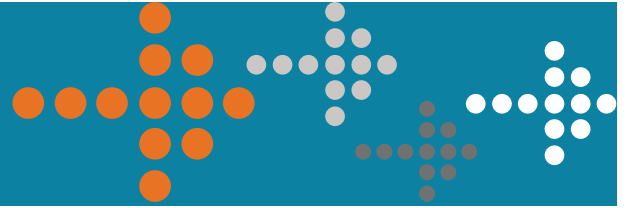




COVID-19 Screening Tool



Name (Print): _____ Department: _____

In-Person (Yes/No): _____ Telephone Call (Yes/No): _____

Date: _____ Time In: _____

IF YOU OR ANY MEMBERS OF YOUR HOUSEHOLD HAVE TRAVELED OUTSIDE OF ONTARIO IN THE PAST 14 DAYS YOU ARE NOT PERMITTED TO ENTER THE _____ FACILITY.

SECTION A: Are you experiencing any of the following symptoms with unknown cause?

- | | | | |
|--|--|---|--|
| • Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Difficulty breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • New onset of cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Loss of taste or smell | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Worsening chronic cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Chills | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Sore throat | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you had contact with any person with, or under investigation for, COVID-19 in the last 14 days? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you or anyone from your household travelled outside of Ontario? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Unexplained fatigue/
malaise/muscle aches (myalgias) | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Nausea/vomiting, diarrhea,
abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| • Pink eye (conjunctivitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| • Runny nose/nasal congestion
without other known cause | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| • Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

OFFICE USE ONLY

In-person, the person being screened was:

- Unfit to work and sent home Yes No
- Sent back to work Yes No
- Referred to a doctor or Public Health with benefit forms (if applicable) Yes No

On the telephone, the person being screened was:

- Instructed to stay or remain at home Yes No
- Referred to go see a doctor or Public Health and sent benefit forms (if applicable) Yes No
- Advised they can come to work Yes No

SECTION B:

If the person being screened was directed to self-quarantine for 14 days post-travel/exposure risk, indicate the start date: dd / mm / yy and the end date: dd / mm / yy.

Date Quarantine was completed: dd / mm / yy.





IF YOU ARE BEING REFERRED TO PUBLIC HEALTH FROM THIS SCREENING, CONTACT THE PUBLIC HEALTH DEPARTMENT FOR YOUR AREA OR TELEHEALTH ONTARIO AT 1-800-797-0000 (FOR THOSE IN ONTARIO).

Facility Representative or H&S Designate: _____ Date: dd / mm / yy.

Please contact your office/clinic H&S Designate for assistance.

Reference: Centers for Disease Control and Prevention website <https://www.cdc.gov/>

Version Date: March 15, 2020 For further information on COVID-19, refer to the

Public Health Agency of Canada <https://www.canada.ca/coronavirus>

June 2, 2020

Government of Ontario Self Assessment: covid-19.ontario.ca/self-assessment/

Public Health Ontario COVID-19 Information: 1-877-604-4567

Public Services Health and Safety Association: 1-877-250-7444



Ontario
Chiropractic
Association