SOUTH LONDON dentalcarecentre™

SouthLondonDental.com

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COVID-19 Screening FORM

First Name: | Last Name: | Date Completed

Staff Screener: | In Office Temperature:

Screening Questions

	Pre-Screen YES	Pre-Screen NO
Do you have any of the following symptoms? • Fever and/or chills • New onset cough or worsening chronic cough • Shortness of breath • Decrease or loss of sense of taste or smell • If over 18, unexplained fatigue, lethargy, malaise, muscle ache (myalgias) • If under 18, nausea, vomiting, diarrhea	◯	◯
Have you tested positive for COVID-19 in the past 10 days, or have you been told you should be isolating?	◯	◯
Have you travelled outside of Canada in the past 14 days?	◯	◯
Have you had close contact with a confirmed case of COVID-19 without wearing appropriate personal protective equipment?	◯	◯
If you answered "Yes" to questions 3 or 4, did you receive your second COVID-19 vaccination dose more than 14 days ago?	◯	◯

Based on your responses in Intiveo so far, I would ask Full Contact whether they're able to make question 5 conditional (i.e. only show it if the patient answers yes to 3 or 4) since lots of patients were answering yes to it even if they answered no to 3 and 4. As discussed, if they need us to insert an updated link in the appointment reminders, feel free to let us know.

Patient Acknowledgment:

☐ I verify that the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to having my dental treatment completed during the COVID-19 pandemic.

I will notify South London Dental Care Centre should I develop any of the above symptoms prior to my scheduled appointment.

Patient/Parent/Guardian Signature

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