** Form translated by Association des denturologistes du Québec for its members only.*

Coronavirus COVID-19

FORM 2A: PATIENTS /ACCOMPANYING PERSONS (for 6 years old and over) SCREENING

(D,H,A,T,DD,P) - Modified September 27, 2021

Name of the person screened:________________________________ **Please indicate if the person named above is the patient or an accompanying person:** ☐ Patient ☐ Accompanying person / Patient's name:________________________	**PRIOR TO APPOINTMENT** **Date:**	**IN CLINIC** **Date:**
1-Are you currently isolating due to a positive COVID-19 result?	☐ Yes ☐ No	☐ Yes ☐ No
2-Are you currently awaiting a COVID-19 test result or was it recommended that you be tested for COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
3-Were you asked to self-isolate (e.g., 14-day self-isolation period upon entering Canada from outside the country, contact with someone who has COVID-19)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you experiencing any of the symptoms below?		
4-Do you feel feverish, experience flu-like chills, or have an orally taken temperature of 38.1°C (100.6°F) and above or 37.8°C (100°F) and above (if you are an elderly)?	☐ Yes ☐ No	☐ Yes ☐ No
5-Do you have a new cough or a chronic cough that has recently worsen?	☐ Yes ☐ No	☐ Yes ☐ No
6-Do you have difficulty breathing?	☐ Yes ☐ No	☐ Yes ☐ No
7-Do you suffer from shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
8-Have you suddenly lost your sense of smell (without nasal congestion) with or without loss of taste?	☐ Yes ☐ No	☐ Yes ☐ No
9- Does your throat ache?	☐ Yes ☐ No	☐ Yes ☐ No
	☐	☐
11–Do you have 2 or more of the following symptoms? Headache Intense fatigue Muscle pain (nonrelated to physical effort) Sore throat Significant loss of appetite Nausea or vomiting Abdominal pain Diarrhea	☐ Yes ☐ No	☐ Yes ☐ No
12-Do you have a known medical condition that would explain the symptoms reported above? If yes, please specify:	☐ Yes ☐ No ☐ Not applicable	☐ Yes ☐ No ☐ Not applicable

Signature of the person who filled the form (patient or office personnel):

Signature prior to appointment:______________________ **Signature in clinic:** __________________________

RESERVED TO DENTAL CLINIC PERSONNEL

- *If the patient answered YES to at least one of the following: STATUS SUSPECTED/CONFIRMED*
  - ✓ *YES to at least one of Questions 1 through 3;*
  - ✓ *YES to at least one of Questions 4 through 11 without other apparent causes (Question 12).*
- *All other instances: STATUS NOT AT RISK*
- **Check the appropriate COVID-19 status for the patient:** ☐ **Suspected/Confirmed** ☐ **Not at risk**

  If the patient is deemed **Suspected/Confirmed**, consult dentist prior to booking appointment