Active Screening Questions: To be completed BEFORE each visit
Please circle the appropriate response

1. **Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?** YES NO

2. **Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?** YES NO

Do you have ANY of the following symptoms:

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- New/Unexplained Headache
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose/nasal congestion without other known cause

YES NO

IF you are 70 years of age or older (if not, you may skip this section): Are you experiencing any of the following symptoms: Delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

YES NO

Name (Print First, Last) Signed Date