shiftCM concussion management

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

1. **In the last 14 days, have you travelled outside of Canada?** 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** *(healthcare or emergency services workers with regular contact risk may be exempt – please notify reception if this applies to you).* YES NO

3. **Has a doctor, healthcare provider, or public health unit told you that you should currently be isolating (staying at home)?** YES NO

4. **In the last 14 days, have you received a COVID Alert exposure notification on your cell phone?** ***(if you already went for a test and got a negative result, select "No")*** YES NO

5. **Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?** YES NO

Do you have ANY of the following symptoms (NOT related to other known causes or existing conditions):

- Fever and/or chills (Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher)
- New cough or barking cough (croup) or worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- New/unexplained headache
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny or stuffy/congested nose
- Additional symptoms for individuals 70 years of age or older: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

YES NO

Name (Print First, Last) Signed Date