# Patient Wellness Screening & Appointment Instructions

**SCOTTSDALE DENTAL CENTRE**
630 SCOTTSDALE DRIVE, GUELPH, ON N1G 3M2
TEL: (519) 836-5110 E-MAIL: SCOTTSDENT@GMAIL.COM

- **This form must be completed the day of your appointment. Please scan it or take a cell phone picture and e-mail to scottsdent@gmail.com**

**Please circle the appropriate responses.**

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 had close contact with a confirmed case of COVID-19? **Yes No**

3. Do you have any of the following symptoms: (circle any that apply)
   - 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
   - Headaches
   - Unexplained fatigue/malaise/muscle aches (myalgias)
   - Nausea/vomiting, diarrhea, abdominal pain
   - Pink eye (conjunctivitis)
   - Runny nose/nasal congestion without other known cause
   - **None of the above**

**In-office Body Temperature**

**_____°C**

4. If you are 70 years of age or older, 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**

**If your response to any of the above questions is 'yes', please contact us to reschedule your appointment and contact your nearest COVID assessment centre.**

By signing on the form below, you agree to the following protocol for your appointment:

- This screening form shall be filled out before appointment on the day of the appointment.
- You consent to have your body temperature taken.
- You agree to wear some kind of facial covering/mask while in the office.
- You agree to use hand sanitizer upon entering and before exiting the dental office.
- You agree to call the office and wait outside upon arrival until we ask you to come inside
- You agree to let us know if you experience any symptoms of COVID-19 within 14 days of your appointment.

**Date:** _____ **Name:** _____ **Signature:** _____