PATIENT SCREENING FORM

Screening Questions	Patient Answer	
Q1. Are you immunocompromised?[1]	YES	NO
Q2: Do you have any of these symptoms? Choose any or all that are new, worsening and not related to other known causes or conditions[2]. • Fever and/or chills • Cough or barking cough • Shortness of breath • Decrease or loss of taste or smell • Muscle aches/joint pain • Extreme tiredness • Sore throat • Runny or stuffy/congested nose • Headache • Nausea, vomiting and/or diarrhea • Abdominal pain • Pink eye	YES	NO
Q3: Have you been told (by a doctor, health care provider, public health unit, federal border agent, or other government authority) that you should currently be quarantining, isolating or staying at home?	YES	NO
Q4: In the last 10 days, have you tested positive for COVID-19 on a laboratory-based PCR test, rapid molecular test, rapid antigen test or other home-based self-testing kit?	YES	NO

Any "yes" response (other than Q1) must be discussed with the managing dentist immediately.

Tell the patient that when they arrive at the office, they will be asked to:

- Sanitize their hands.
- Have their temperature taken (depending on the dental office's policies).

[1] Factors such as old age, diabetes and end-stage renal disease are generally not considered immunocompromised. Examples of being immunocompromised include individuals:

- undergoing cancer chemotherapy
- with untreated HIV infection with CD4 T lymphocyte count less than 200
- with combined primary immunodeficiency disorder
- on prednisone medication - more than 20 mg per day (or equivalent) for more than 14 days
- on other immune suppressive medications.

[2] Select "No" if all of these apply:

- you do not have a fever, **and**
- your symptoms have been improving for 24 hours (48 hours if you have nausea, vomiting, and/or diarrhea)