



CLIENT SCREENING FOR COVID-19

Client Name: _____

Do you have severe difficulty breathing or severe chest pain or feel confused or lost consciousness? If yes, call 911 or go to your emergency department.

Part A	First Shift	Second Shift	Excursion Time:	Excursion Time:
What is your temperature? <i>If 37.8 degrees Celsius or above immediately call a manager or oncall.</i>				
Are you experiencing any of these symptoms? Check any/all that apply.				
chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
cough that's new or worsening (<i>Continuous, more than usual</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
barking cough, making a squeaky or whistling noise when breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
shortness of breath (<i>out of breath, unable to breath deeply</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
sore throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
difficulty swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hoarse voice (<i>more rough or harsh than normal</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
runny nose or nasal congestion without other known cause	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pink eye (conjunctivitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
lost sense of taste or smell	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
digestive issues (<i>nausea/vomiting, diarrhea, stomach pain</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unexplained fatigue/ malaise/ muscle aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
falling down more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part B

In the last 14 days, have you travelled to or returned from a destination outside of Northwestern Ontario?
 Yes ____ No ____ If yes, where? _____

In the last 14 days, have you had close contact with someone who has or is suspected of having COVID-19?
 Yes ____ No ____

In the last 14 days, have you been diagnosed with COVID-19 by a lab test or are you waiting for the results of a lab test for COVID-19? Yes ____ No ____

If any symptoms have been checked off in Part A or client answered Yes to any of the questions in Part B, please contact a Manager or Director during office hours at 345-9933 or an On-Call Supervisor after office hours at 626-4825 for further direction.

Staff Name

Signature

Date