NON-VERBAL CLIENT SCREENING FOR COVID-19

Client Name:_____

Does the client 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 the client's temperature? ***If 37.8 degrees Celsius or above immediately call a manager or oncall.***				
Does it appear that the client is experiencing any of these symptoms? Check any/all that apply.				
chills	◯	◯	◯	◯
cough that's new or worsening *(Continuous, more than usual)*	◯	◯	◯	◯
barking cough, making a squeaky or whistling noise when breathing	◯	◯	◯	◯
shortness of breath *(out of breath, unable to breath deeply)*	◯	◯	◯	◯
sore throat	◯	◯	◯	◯
difficulty swallowing	◯	◯	◯	◯
hoarse voice *(more rough or harsh than normal*)	◯	◯	◯	◯
runny nose or nasal congestion wihtout other known cause	◯	◯	◯	◯
Pink eye (conjunctivitis)	◯	◯	◯	◯
lost sense of taste or smell	◯	◯	◯	◯
headache	◯	◯	◯	◯
digestive issues *(nausea/vomiting, diarrhea, stomach pain)*	◯	◯	◯	◯
Unexplained fatique/ malaise/ muscle aches	◯	◯	◯	◯
falling down more than usual	◯	◯	◯	◯

Part B

In the last 14 days, has the client travelled to or returned from a destination outside of Northwestern Ontario?

Yes ____ No ____ If yes, where? _____

In the last 14 days, has the client had close contact with someone who has or is suspected of having COVID-19?

Yes ____ No ____

In the last 14 days, has the client been diagnosed with COVID-19 by a lab test or is 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

(July 20, 2020)