DENTAL ASSOCIATION of PRINCE EDWARD ISLAND
MEMBER OF THE CANADIAN DENTAL ASSOCIATION

Patient Screening Form

Use this form to screen patients before their appointment and when they arrive for their appointment.

Staff screener: _____

Patient Name: _____ Patient age: _____

Who answered: ___ Patient ___ Other (specify) _____

Contact Method: ___ Phone ___ email ___ Other _____

Identify yourself and explain the purpose of the call, which is to determine whether there are any special considerations for their dental appointment. Have the patient answer the following questions.

Screening Questions	Pre-Screen	In-Office
1. Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at appointment: _____. If elevated, provide mask to patient.	YES NO	YES NO
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose?	YES NO	YES NO
3. Have you experienced a recent loss of smell or taste?	YES NO	YES NO
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES NO	YES NO
5. Have you returned from travel outside of Canada in the last 14 days?	YES NO	YES NO
6. Have you returned from travel within Canada from a location known affected with COVID-19?	YES NO	YES NO
7. Is your workplace considered high risk?	YES NO	YES NO

Patient Vulnerability

8. Are you over the age of 60?	YES NO	YES NO
9. Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES NO	YES NO

- Any "yes" response for questions 1-7 must be discussed with the managing dentist immediately.
  - Tell the patient when they arrive at the office, they will be asked to: sanitize their hands; answer the questions again; have their temperature taken; complete a form acknowledging the risk of COVID-19.
- Advise the patient:
  - Only patients are allowed to come to the office.
  - If possible to wait in their car until their appointment, call the office when they arrive.

READ BEFORE ENTERING CLINIC

In response to covid-19, additional steps have been taken to further enhance your safety and the safety of our staff. Only individuals being treated are allowed to enter the clinic. Accompanying persons are not permitted to enter, with the exception of caregivers.

Delivery personnel are to contact the facility staff prior to entering.

Please review the following questions to confirm your fitness to enter the facility.

1. **Do you currently have any of the following symptoms?**
   - ➔ **Severe Cough**
   - ➔ **Muscle pains**
   - ➔ **Significant Nasal congestion**
   - ➔ **Fever > 38 Degrees C**
   - ➔ **Shortness of breath**
   - ➔ **Headache**
   - ➔ **Runny nose**
   - ➔ **Reduced or lost sense of smell**
2. **Have you failed to use physical distancing in the last two weeks?**
3. **Have you come into contact with anyone that has any of the above symptoms in the last two weeks?**
4. **Have you come into contact with anyone suspected of having Covid-19 in the last 2 weeks?**
5. **Have you come into contact with anyone diagnosed with COVID-19 in the past 2 weeks?**

If you have answered "yes" to any of the above questions,

DO NOT ENTER THE FACILITY.

Call our phone number below and you will be given the appropriate direction.

Only enter the clinic if you answered "No" to all the questions above.

Call us if you have any questions: (_____) _____.

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Patient Acknowledgement COVID-19 Treatment Consent

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the Federal and Provincial governments have asked individuals to maintain social distancing of a least 2 metres (6 feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment.** _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one possible way that the novel coronavirus can spread. . _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I may have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office. _____** (initial)

I verify the information I have provided on this form and during the other screening questions I have been asked is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT _____ Date _____

Adapted from Dental Association of PEI *COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient*.