COVID-19 Patient and Staff Assessment Form

\* All fields are Required

Name: \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature\* \_\_\_\_\_\_\_

Phone number or email address: \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last 14 days, have you returned from travel outside of Canada? \*

* Yes
* No

In the last 14 days, have you been in close contact with anyone with suspected or confirmed COVID-19? \*

* Yes
* No

Are you curre

ntly waiting for COVID-19 test results? \*

* Yes
* No

In the last 14 days, have you lived or worked in a setting that is part of a COVID-19 outbreak? \*

* Yes
* No

In the last 14 days, have you been advised to self-isolate or quarantine at home by public health? \*

* Yes
* No

Do you have any of the following COVID-19 like symptoms? \*

* Fever
* Cough
* Shortness of breath
* Diarrhea
* Nausea and/or vomiting
* Headache
* Runny nose / nasal congestion
* Sore throat / painful swallowing
* Loss of sense of smell
* Loss of appetite
* Chills
* Muscle aches
* Fatigue
* NONE of the above.

We are following the infection prevention and control guidelines from WorkSafeBC & BCCDC. However, it is not possible to guarantee a 100% risk free environment. Do you feel the benefit of receiving treatment outweighs the risk involved? \*

* Yes
* No

**Client Signature:** \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are displaying any symptoms consistent with COVID-19, you have to return home and you should not enter the premise and refer to the HealthLink BC at 811