COVID-19 Screening Tool
(Updated June 2, 2020)

1. Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?

2. Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?

→If **NO**, continue to question 3

→ If **YES**

→ Did you wear the required and/or recommended PPE according to the type of duties /care you were performing (goggles, gloves, mask, gown or N95) when you had close contact with a suspected or confirmed case of COVID-19?

→ If **NO**, please talk with staff

→If **YES**, continue to question 3

3. Do you have any of the following symptoms that are **NEW** or **WORSENING**?

- Fever
- New onset of Cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- Decreased or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose/nasal congestion without other known cause

3. If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

If **NO** to ALL Questions – patient screened **NEGATIVE**