Patient Pre-Screening Questionnaire

CAO ACO
CANADIAN ASSOCIATION OF ORTHODONTISTS — Setting It Straight
ASSOCIATION CANADIENNE DES ORTHODONTISTES — Disons les vraies choses

NAME: _____ **DATE:** _____

QUESTIONS	ANSWERS
Does patient have fever or have you/they felt hot or feverish recently (the last 14 days)?	☐ Yes ☐ No
Does the patient have shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Does the patient currently have a cough?	☐ Yes ☐ No
Does the patient have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Has the patient experienced recent loss of taste or smell?	☐ Yes ☐ No
Has the patient been in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No
Has the patient traveled in the past 14 days?	☐ Yes ☐ No

COVID-19 Pandemic Dental Treatment Consent Form

Patient name: _____ **Temperature**:_____

CMOH Order 05-2020 legally obligates any person who has the following cough, fever, shortness of breath, runny nose, or sore throat (that is not related to a pre-existing illness or health condition) to be in isolation (quarantine) for 10 days from the start of symptoms, or until symptoms resolve, whichever takes longer. If they are exhibiting any of these symptoms, it is suggested they complete the COVID-19 Self-Assessment online tool to determine if they should be tested.

I or my child understand the novel coronavirus causes the disease known as COVID-19. I or my child understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. **_____ (Initial)**

I or my child understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I or my child have an elevated risk of contracting the novel coronavirus simply by being in a dental office. **_____ (Initial)**

I or my child confirm that we are not presenting any of the following symptoms of COVID-19 identified by Alberta Health Services:

- Fever > 38°C
- New cough or worsening chronic cough
- Sore throat or painful swallowing
- New or worsening shortness of breath
- Difficulty Breathing
- Flu-like symptoms
- Runny Nose/Loss of Smell

_____(Initial)

I or my child confirm that we know that there are categories of people who are considered to be high risk. I or my child understand the high risk category factors are; **being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder**. I or my child do not fall into the above high risk categories and we have agreed to proceed with treatment. **_____ (Initial)**

I or my child confirm that to my knowledge we are not currently positive for the novel coronavirus. **_____ (Initial)**

I or my child confirm that we are not waiting for results of a laboratory test for the novel coronavirus that was ordered due to contact tracing or because I or my child had identified risk factors. **_____ (Initial)**

Please note: *Any individual who has gone in for testing on their own volition as an asymptomatic individual does not need to indicate that.*

I or my child verify that we have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train in the past 14 days. **_____ (Initial)**

I or my child understand that any travel from any country outside of Canada, including travel by car, air, bus, boat or train, significantly increases my risk of contracting and transmitting the novel coronavirus. Alberta Health Services require self-isolation for 14 days from the date a person has returned to Canada. **_____ (Initial)**

I or my child understand that Alberta Health Services has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive orthodontic treatment. **_____ (Initial)**

I or my child verify that we have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Alberta Health, the Communicable Disease Control or any other governmental health agency. **_____ (Initial)**

OR

I am a healthcare worker who has worn appropriate PPE. **_____ (Initial)**

I or my child verify the information we have provided on this form is truthful and accurate. I/ my child knowingly and willingly consent to have orthodontic treatment completed during the COVID-19 pandemic.

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

Printed Name:_____ **Date:**_____