Staff/ Student screener:

Patient Name: UBC Chart Number: \_\_\_\_\_\_\_\_\_\_\_Patient age:

Companion Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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. If the patient requires a companion, both persons must be screened.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Screening Questions** | **Pre-Screen** | | **In-Office** | |
| 1. Do you or your child have a fever or have felt hot or feverish anytime in the last two weeks?   Patient temperature at appointment: \_\_\_\_\_\_\_\_. If elevated, provide mask and ask patient to return home and monitor symptoms. | YES | NO | YES | NO |
| 1. Do you or your child have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip? | YES | NO | YES | NO |
| 1. Have you or your child experienced a recent loss of smell or taste? | YES | NO | YES | NO |
| 1. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19? Has your child? | YES | NO | YES | NO |
| 1. Have you or your child returned from travel outside of Canada in the last 14 days? | YES | NO | YES | NO |
| 1. Have you or your child returned from travel within Canada from a location known affected with COVID-19? | YES | NO | YES | NO |
| 1. Is your workplace considered high risk? | YES | NO | YES | NO |
| **Patient Vulnerability** |  |  |  |  |
| Are you over the age of 70? | YES | NO | YES | NO |
| 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 instructor immediately.
  + Inform the patient that no appointment can be booked until positive answer clarified
* Advise the patient/parent:
  + Only patients are allowed to come to the office, except one person accompanying a minor
  + 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.
  + If possible to wait in their car until their appointment, call the office when they arrive.

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

|  |  |
| --- | --- |
| I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious.*** For this reason, it is recommended to stay home and avoid close contact with other people when at all possible | (Initials) |
| I understand the federal and provincial governments have asked individuals to maintain social distancing of a least 2 meters (6 feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment** | (Initials) |
| I understand that it is possible that oral surgery/dental procedures can create water and/or blood spray, which may be one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. | (Initials) |
| I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I/ my child have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office.** | (Initials) |
| I confirm that I/my child do NOT have any of the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache | (Initials) |
| I confirm that I/my child have not tested positive for COVID-19. | (Initials) |
| I confirm that I/my child am not waiting for the results of a test for COVID-19. | (Initials) |
| I confirm that this is not currently a period where I/my child required to self-isolate for 14 days. | (Initials) |
| I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. | (Initials) |

Signature of Patient/Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chart # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s name (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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