PARK DENTAL™

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
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
Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose?	YES NO	YES NO
Have you experienced a recent loss of smell or taste?	YES NO	YES NO
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
Have you returned from travel outside of Canada in the last 14 days?	YES NO	YES NO
Have you returned from travel within Canada from a location known affected with COVID-19?	YES NO	YES NO
Are you over the age of 60?	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 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

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Patient Acknowledgement: COVID-19 Pandemic Emergency Dental Risk

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. _____ (initial)

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 important 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. _____ (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 have an elevated risk of contracting AND SPREADING the novel coronavirus simply by being in the dental office. _____** (initial)

I have been made aware that the Province/Territory of _____ has, under the current pandemic, mandated that **only emergency dental care is allowed.** Dental visits must be limited to only the essential treatment of ongoing bleeding, trauma, significant infection not responding to antibiotics and pain killers, or to alleviate severe pain that does not respond to antibiotics and pain killers. I confirm that I meet one of more of these criteria. _____ (initial)

I confirm and accept that emergency treatment provided may not necessarily be representative of the care that would be expected or provided under normal circumstances and will be very limited to only simple emergency care. For example, a tooth would be removed rather than a root canal of filling done in this emergency situation. _____ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: fever, new or worsening cough, sore throat, runny nose or headache. _____ (initial)

I confirm that I have not tested positive for COVID-19. _____ (initial)

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period where I required to self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have emergency surgical/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*.