



Screening questions prior to attending appointment or staff returning to office:

- 1) Have you travelled outside of Canada within the past 14 days?
- 2) Have you travelled outside of Northern Ontario (Manitoba border to Parry Sound) within the past 7 days?
- 3) Have you recently been tested for COVID-19 due to symptoms and are currently awaiting test results?
- 4) Have you been in close contact with someone who is confirmed to currently have COVID-19 within the past 14 days?
- 5) Are you currently, or have you in the past 24-hours, been feeling unwell OR do you have any new unexplained symptoms related to COVID-19?

Symptoms could include:

- | | | |
|---|------------------------------|-----------------------------|
| <input type="radio"/> Fever (feeling hot to touch, a temperature of 37.8 or higher) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> New or worsening cough (continuous, more than usual) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Barking cough or making a whistling when breathing (croup) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Shortness of breath, difficulty breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Difficulty swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Lost sense of taste or smell | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Chills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Headache that is unusual or long-lasting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Muscle aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Nausea/vomiting, diarrhea, abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Pink eye (conjunctivitis) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Runny, stuffy or congested nose (not related to seasonal allergies or other known causes or conditions) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Extreme tiredness that is unusual (fatigue, lack of energy) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="radio"/> Sluggishness or lack of appetite (especially in young children) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you should answer YES to any of these questions, please do not enter this facility.

You are required to self-isolate and contact your nearest assessment centre OR Telehealth Ontario at 1-866-797-000. For a list of assessment centres, visit TBDHU.COM/testinginfo.