COVID-19 :

PATIENT / ATTENDANT SCREENING

In order to protect your health and safety as well as that of staff members and other patients during this exceptional period caused by COVID-19, the following persons must have completed this form **before** coming to the appointment :

- The patient ;
- The attendant, *i.e.* the parent, the legal guardian or the person accompanying the patient.

Depending on the procedures specific to your clinic, this form can be completed :

- On the phone with the secretary ;
- By email (on your computer, tablet or smartphone iPhone / Android).

Please use Acrobat Reader (macOS / Windows) or Acrobat (iOS / Android). Using other apps may not work properly.

DO NOT FILL IN ANYTHING LOCATED IN A GREY AREA UNLESS TOLD OTHERWISE.

Surname ______________________ F. name ______________________

If you are the attendant, fill in the full name of the patient below :

Surname ______________________ F. name ______________________

	BEFORE THE APPOINTMENT		AFTER ARRIVAL AT THE CLINIC	
	Date D/M/Y :		Date D/M/Y :	
	YES	NO	YES	NO
1. Have you had a positive COVID-19 screening test in the last 21 days, received a recommendation to get tested, or are you awaiting a screening test result ?	☐	☐	☐	☐
Do you have the following conditions				
2. Fever (over 38 °C or 100,4 °F) ?	☐	☐	☐	☐
3. Recent or chronic cough that has gotten worse ?	☐	☐	☐	☐
4. Difficulty breathing (*e.g.* shortness of breath or difficulty speaking) ?	☐	☐	☐	☐
5. Sudden loss of smell (with or without loss of taste) ?	☐	☐	☐	☐
6. Muscle pain, headache, intense fatigue or severe loss of appetite ?	☐	☐	☐	☐
7. Sore throat ?	☐	☐	☐	☐
8. Diarrhea ?	☐	☐	☐	☐
9. Do you have a known health condition that can explain the symptoms reported above? If **YES**, specify : ______________________	☐	☐	☐	☐
10. Have you been in close contact (at least 15 minutes within 2 metres) with a confirmed or probable case of COVID-19 ?	☐	☐	☐	☐

The person who completed the form must sign the form :

Need help to sign the form? Refer to your clinic or follow the instructions of the app available in-app or online.

Patient ☐ Attendant ☐

I, the undersigned, solemnly declare that the answers contained in the form above are true

______________________ Signature before the appointment

______________________ Signature after arrival at the clinic

Staff member ☐ ***N.B. Staff member signing must write their first name next to the signature***

Ask the following question to the patient / the attendant :

"Do you solemnly declare that the answers that you gave are true ?"

YES ☐ NO ☐ YES ☐ NO ☐

Staff first name	Signature before the appointment	Signature after arrival at the clinic	Staff first name

SECTION RESERVED FOR THE CLINIC

If the patient answered :

1. **YES** to question 1 → COVID-19 status is SUSPECTED / CONFIRMED ;
2. **YES** to at least ***one*** of questions 2 to 5 AND **NO** to question 9 → COVID-19 status is SUSPECTED / CONFIRMED ;
3. **YES** to at least ***two*** of questions 6 to 8 AND **NO** to question 9 → COVID-19 status is SUSPECTED / CONFIRMED ;
4. **YES** to question 10 → COVID-19 status is SUSPECTED / CONFIRMED ;
   N.B. Healthcare workers who have provided care to a confirmed / suspected COVID-19 case with appropriate PPE are excluded ;
5. Any other answer → COVID-19 status is ASYMPTOMATIC.

Check the box corresponding to the patient's COVID-19 status : Asymptomatic ☐ Suspected / Confirmed ☐

If the patient is suspected / confirmed COVID-19, consult the dentist before booking an appointment.