COVID-19 POINT OF CARE PATIENT RISK ASSESSMENT

The Regional Fertility Program is committed in providing a safe environment for all our staff and patients during the COVID-19 pandemic.

	Patient Name: _____		Partner or support person Name: _____	
1. Do you have any of the following symptoms that are new: a) Fever (over 38°C), cough, shortness of breath, sore throat, runny nose, loss of smell and/or taste?	Yes	No	Yes	No
b) Vomiting or diarrhea?	Yes	No	Yes	No
c) Stuffy nose, painful swallowing, chills, headache, muscle/ joint aches, fatigue/ extreme exhaustion, nausea/ unexplained sudden loss of appetite, conjunctivitis/ pink eye?	Yes	No	Yes	No
2. Do you have any symptoms listed above that are not new, but possibly associated with allergies, chronic or pre-existing conditions?	Yes	No	Yes	No
3. Have you travelled outside of Canada in the last 14 days AND directed to quarantine?	Yes	No	Yes	No
4. Have you tested positive for COVID-19 in the last 10 days?	Yes	No	Yes	No
5. Have you tested positive for COVID-19 in the last 3 months?	Yes	No	Yes	No