MAPLECARE PHYSIOTHERAPY & NEURO REHAB CENTRE

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COVID-19 Screening Form

For ALL IN-CLINIC Patients and Visitors, It is required to fill out this screening questionnaire for EACH VISIT to the clinic.

Full Name:

Email:

Please Carefully read and answer ALL the following questions:

Have you had close contact with anyone with acute respiratory illness or someone who has travelled outside of Canada in the past 14 days? ◯ Yes ◯ No

Have you had COVID-19 or come in contact with a confirmed or suspected case of COVID-19 in the past 2 weeks? ◯ Yes ◯ No

Do you currently have ANY of the following symptoms:
•Fever •New onset of cough •Worsening chronic cough •Shortness of breath •Difficulty breathing •Sore throat •Difficulty swallowing •Decrease or loss of sense of taste or smell •Chills •Headaches •Unexplained fatigue/malaise/muscle aches (myalgias) •Nausea/vomiting, diarrhea, abdominal pain •Pink eye (conjunctivitis) •Runny nose/nasal congestion without other known cause? ◯ Yes ◯ No

Does anyone living in your household have ANY of the above symptoms? ◯ Yes ◯ No

If you are 70 years of age or older, are they experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? ◯ Yes ◯ No

If you answer "YES" to any of above questions, we ask you to :

Please call the clinic and cancel your "in person" appointment and discuss other treatment options. Call your primary care provider or Telehealth Ontario at 1-866-797-0000 or Public Health Ottawa at 613-580-6744 for further clinical assessment.

Declaration:

1. I have answered all the above questions honestly and truthfully. Please call our clinic and cancel your in person appointment. We will be happy to provide you treatment through telerehab.
2. By signing below, I consent and accept the inherent risks of in-person physiotherapy treatment in light of the COVID-19 Pandemic and any potential exposure that occurs as a result.

Please write Patient/Visitor Full Name below which serves as electronic signature:

NAME (Patient/Visitor) _____ **DATE** _____

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