

PATIENT COVID-19 SCREENING

PLEASE SELECT "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

First Name: Last Name:

Birth Date: Gender:

Address:

Email: Phone:

01

Do you currently have a fever?

YES NO



Do you currently have a cough?

YES NO

02

03

Do you currently have difficulty breathing?

YES NO



In the last 14 days, have you traveled outside of Canada?

YES NO

04

05

In the last 14 days, have you come into contact with someone who was suspected or confirmed to have COVID-19?

YES NO



In the last 14 days, have you come into contact with someone who was unwell or ill (in any capacity)?

YES NO

06

SIGNATURE

If you answered "Yes" to any of the above questions, please stay home and complete the Alberta online COVID-19 self-assessment:

<https://myhealth.alberta.ca/journey/covid-19/Pages/COVID-Self-Assessment.aspx>

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