Hospital Patient/Essential Care Partner Screening Form

Please complete this form prior to proceeding to screening on the day of your appointment.

Thunder Bay Regional Health Sciences Centre

I am a: ☐ Patient ☐ Essential Care Partner

Your Name: _____

Today's Date: _____

Patient's Name you are visiting: _____

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1 Are you experiencing one of the following new or worsening symptoms:

- Fever
- Cough
- Difficulty breathing
- Muscle aches
- Fatigue
- Headache
- Sore throat
- Runny nose/ sneezing
- Nasal congestion
- Hoarse voice
- Difficulty swallowing
- Chills
- Change in sense of small/taste
- Gastrointestinal symptoms (e.g. nausea, vomiting and/or diarrhea)?

☐ YES ☐ NO

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2 Have you travelled outside of Northwestern Ontario (Manitoba Border to White River) in the last 14 days?

☐ YES ☐ NO

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3 Have you had close contact without personal protective equipment (PPE) with anyone with a confirmed or probable (being tested at present) case of COVID-19?

☐ YES ☐ NO

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4 In the last 14 days, have you been diagnosed with COVID-19 by a lab test or are you waiting for results of a lab test for COVID-19?

☐ YES ☐ NO