COVID-19 SCREENING QUESTIONNAIRE

PLEASE READ AND SIGN BELOW

Risk Assessment: Screening Questions

1.	Do you have any of the following symptoms which are new or worsened if associated with allergies, chronic or pre-existing conditions: fever, cough, shortness of breath, difficulty breathing, sore throat, and/or runny nose?	Yes	No
2.	Have you returned to Canada from outside the country (including USA) in the past 14 days?	Yes	No
In the past 14 days, at work or elsewhere, while not wearing appropriate personal protective equipment:			
3.	Did you have close contact* with someone who has a probable** or confirmed case of COVID-19?	Yes	No
4.	Did you have close contact* with a person who had acute respiratory illness that started within 14 days of their close contact* to someone with a probable** or confirmed case of COVID-19?	Yes	No
5.	Did you have close contact* with a person who had acute respiratory illness who returned from travel outside of Canada in the 14 days before they became sick?	Yes	No
6.	Did you have a laboratory exposure to biological material (i.e. primary clinical specimens, virus culture isolates) known to contain COVID-19?	Yes	No

By signing below, I affirm I would like to proceed with my appointment at Creekside Physiotherapy and:

1. I hereby confirm that I answered **NO** to all the questions being asked in the above screening questionnaire and that the information above is true to my knowledge. would like to proceed with care on this basis.
2. I understand that my provider is following all applicable guidelines from BC Public Health and operating under ***enhanced protocols*** but there are still unknown aspects to SARS-COV-2, the virus that causes COVID-19, and I agree to hold harmless my provider for any possible exposure that may occur as a result of this appointment.

_____ _____

Name and Signature Date

417 D, 304th St. Kimberley BC V1A 3H4 (250) 427-2202 Fax: 1-888-839-6010
www.creeksidephysiotherapy.ca info@creeksidephysiotherapy.ca