HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

VISITOR SCREENING FORM

I am: ☐Visiting an inpatient ☐Assisting a patient to an appointment.

Today's Date: _____Time:_____

I am here visiting an inpatient:

Patient First and Last Name _____Room# _____

I am here to assist a patient to an appointment:

Patient's First and Last Name: _____

My Contact Information

First and Last Name: _____

Phone: _____

1. Do you have a fever, cough, shortness of breath or decrease or loss of smell or taste?
   Yes □ **No** □

2. Have you travelled outside of Canada & been told by Border Services Agency (CBSA) to quarantine?
   Yes □ **No** □

3. Have you had any contact with a confirmed or probable case of COVID-19 or a person with acute respiratory illness (fever, cough, shortness of breath) who has travelled outside of Canada in the last 14 days? **Yes** □ **No** □

4. Do you have <u>two (2) or more</u> of the following symptoms below? **Yes** □ **No** □

□ Sore throat	□ Headaches	□ Pink eye (conjunctivitis)
□ Unexplained fatigue/malaise	□ Runny nose/sneezing without other known cause	□ Muscle Aches or Joint pain
□ Nausea/vomiting and/or Diarrhea	□ Abdominal pain	□ Nasal congestion without other known cause

I have read, and understand The VISITOR REQUIREMENTS that is posted at the screening desk.

_____ _____

Visitor Signature **Date**

FOR OFFICE USE ONLY: Screeners initials they have viewed proof

Proof of Vaccination verified: _____
Proof of Rapid Antigen Test Verified: _____
Date of Test: _____ **Result:** _____