WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

C O V I D 1 9

VISITOR / PATIENT COVID-19 SCREENING FORM

Please complete the following form prior to proceeding to screening.

I am a: ☐ Visitor ☐ Patient

Today's Date:_____
(MM/DD/YYYY)

Patient's Name:_____ _____
(First Name) *(Last Name)*

Patient's Date of Birth:_____
(MM/DD/YYYY)

YOUR CONTACT INFORMATION

Your Name:_____ _____
(First Name) *(Last Name)*

Your Phone Number:_____

Your Address:_____

1. In the last 14 days have you travelled outside of Canada? ☐ Yes ☐ No

2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? ☐ Yes ☐ No

3. Do you have any **ONE** of the following symptoms? ☐ Yes ☐ No

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Hoarse Voice
- Difficulty swallowing
- Decrease or loss of sense of taste/smell
- Chills
- Headaches
- Unexplained fatigue/malaise/muscle aches
- Diarrhea
- Abdominal pain
- Nausea/vomiting
- Pink eye (conjunctivitis)
- Runny nose/sneezing without other known cause
- Nasal congestion without other known cause

4. If you are 70 years of age or older, are you experiencing any of the following? ☐ Yes ☐ No

- Delirium
- Unexplained or increased number of falls
- Acute functional decline
- Worsening of chronic conditions

NOTE: **If you pass the screening you will be provided a mask that you must wear while at the hospital.**