**CLINIC NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Screening Form Phase 2 Triage**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_Sex:\_\_\_\_\_Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Body Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **QUESTION** | YES | NO |
| 1. In the past 14 days, have you or any member of your household, traveled to any areas with known cases of COVID-19 |  |  |
| If so, please state the exact location | | |
| 2. In the past 14 days, have you or any member or your household has had any contact  with any COVID-19 patient? |  |  |
| 3. Have you or any household member have any history of exposure to any COVID-19  biological material (e.g. saliva) |  |  |
| 4. Have you had any history of fever for the last 14 days? |  |  |
| 5. Have you had any symptoms in the last 14 days such as: cough, nausea, diarrhea, loss of taste, difficulty breathing, body ache, loss of smell, fever? |  |  |
| 6. Urgent dental need in the last 14 days such as un controlled dental/oral pain, swelling,  bleeding, infection, trauma? |  |  |
|  | | |
| **INFORMED CONSENT** | **Conforme (Please Sign initial)** | |
| 1. I give my full consent to have dental treatment done to me in this time of pandemic  caused by COVID-19 disease. |  |  |
| 2. As explained by my dentist, the virus can be transmitted by contact through surfaces  and that it can stay in the air for 5 to 72 hours. I am aware that it is impossible to identify  who is probable, suspect or COVID-19 positive. Because of this, treatment options are  limited to urgent and emergent care to protect me, other patients and the dental staff. |  |  |
| 3. I recognize that the clinic is adhering to the strictest infection control protocols  for my protection and such, I agree cover the fees that this entails. |  |  |
| 4. I fully understand The risk that because of the nature of the virus, travelling to the  clinic, the clinical procedures, and even by simply staying in the dental office, I have a  higher chance of contracting the virus. Should I contract the virus, I hereby agree that  I shall not hold the dental office liable. |  |  |
| 5. I am also giving my consent that in accordance to the IATF rules, my identity shall be  revealed for possible contact tracing for the interest and safety of the community. |  |  |
| I am TRUTHFULLY answering the questionnaire and fully understood the informed consent form.  CONFORME: (sign here) | | |
| Patient’s or Guardian’s Full Name :  Relation to Patient: | | |
| Date signed: | | |