COVID-19 Screening

1) Have you had close contact with anyone with acute respiratory Illness or travelled outside of **Ontario** in the past 14 days?
2) Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
3) Do you have any of the following symptoms:
    - Fever, Chills, Headaches
    - New onset of cough or Worsening chronic cough
    - Shortness of breath or Difficulty breathing
    - Sore throat or Difficulty swallowing
    - Decrease or loss of sense of taste or smell
    - Unexplained fatigue/malaise/muscle aches (myalgias)
    - Nausea/vomiting, diarrhea, abdominal pain
    - Pink eye (conjunctivitis)
    - Runny nose/nasal congestion without other known cause
4) If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

COVID-19 Screening Results

If response to **ALL** of the screening questions is **NO**: ***COVID Screen Negative***
If response to **ANY** of the screening questions is **YES**: ***COVID Screen Positive***