NIISAACHEWAN ANISHINAABE NATION

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COVID-19 SCREENING TOOL

Client's Temperature	
Have you or someone you have been in close contact with recently been tested for COVID-19? If yes, when_____/result _____	YES/NO
In the past 14 days have you been in contact with anyone that has had a respiratory infection?	YES/NO
Have you travelled outside of the Kenora District in the past 14 days?	YES/NO
Do you have a fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing?	YES/NO
Do you have any of the following symptoms? Sore throat, difficulty swallowing, decrease or loss of taste or smell, chills, headaches, unexplained fatigue/malaise, diarrhea, abdominal pain, or nausea/vomiting, pink eye (conjunctivitis)? Runny nose or nasal congestion without other known cause?	YES/NO
Are you over 70? If so, have you experienced any delirium, unexplained or increased # falls, acute functional decline, or worsening of your chronic health conditions?	YES/NO

Name: _____

DOB (YY/MM/DD): _____

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

Screeners Initials ___ **Positive Screen ____** **Negative Screen ___**