

## Orthodontic COVID-19 Screening Questionnaire

<b>Patient's Name:</b>		<b>Date of Birth:</b>	
<b>Phone No of:</b> carer/guardian/patient (please circle)		<b>Name of carer/guardian:</b> (if applicable)	

<b>Patient Address:</b>

### COVID-19 TRIAGE

<b>Have you been diagnosed with coronavirus?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Have you been in contact with someone with confirmed coronavirus?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Are you or your household self-isolating?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Do you or have you had a temperature (&gt;37.8°C) in the last 14 days?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Do you or have you had a persistent dry cough in the last 14 days?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Do you have a change/loss in your taste/smell?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Do you have any <u>new</u> symptoms of shortness of breath?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Are you a shielded patient group?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<b>Details:</b>	

### I confirm:

<b>I will notify the department to change my/my child's appointment if any symptoms of the virus develop after completion of this questionnaire</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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<b>I am aware that I can contact the department to discuss any concerns about attending the appointment with a member of the team</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>I am aware that my attendance is voluntary and I accept the risk of attending during the Covid-19 pandemic</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Signed (Parent/Guardian/Patient) .....**

**Date .....**