Resident Daily Screening Questionnaire

This screener is be completed as a self-check by all residents for signs of COVID-19. For any resident unable to complete a self-check, staff must complete the questionnaire for any resident who has routine interface with staff (e.g. personal care) at least once daily. Documentation of screening must be kept in the resident chart.

In addition, any resident leaving the site must be screened at re-entry.

Screening must include temperature check using a non-invasive infrared or similar device.

Please complete the following COVID-19 Resident Questionnaire:

1. Do you/Does the resident have any of the following symptoms: CIRCLE ONE
   • Fever (37.8 degrees Celsius or higher) YES NO
   • Any new or worsening respiratory symptoms:
     ○ Cough YES NO
     ○ Shortness of Breath / Difficulty Breathing YES NO
     ○ Runny Nose or sneezing YES NO
     ○ Nasal congestion YES NO
     ○ Hoarse voice YES NO
     ○ Sore throat YES NO
     ○ Difficulty swallowing YES NO
   • Any new onset atypical symptoms including but not limited to:
     • Chills YES NO
     • Muscle Aches YES NO
     • Nausea / Vomiting / Diarrhea YES NO
     • Feeling unwell / Fatigued / Malaise YES NO
     • Headache YES NO

Operators must be aware of, and follow, any applicable privacy legislation (e.g., Freedom of Information and Protection of Privacy Act, Health Information Act, Personal Information Protection Act, etc.), should they document/retain the Health Assessment Screening completed with residents and staff (or others).

If any resident answers YES to any question, the individual shall immediately be isolated in the facility.

Completed By: ____________________________________________

Date: ________________________________________________

Current as of April 11, 2020 and CMOH Order 10-2020