Alberta Health Services

Resident Daily Screening Questionnaire

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X)		

A questionnaire must be completed prior to providing care.

Documentation of screening MUST be kept in the resident chart with the exception of point of entry screening.

Indicate presence of symptom(s) by placing check marks ✓ in "Yes" or "No" boxes.

If the patient has any of the **BOLDED symptoms** ***(fever, cough, shortness of breath/difficulty breathing, runny nose, or sore throat)*** they are required to isolate for 10 days as per CMOH Order 05-2020 unless they receive a negative COVID-19 test and their symptoms have resolved.

If a resident answers YES to any of the questions 1-4, the individual must immediately:

- Be given a procedure/surgical mask
- Initiate isolation with contact and droplet precautions
- Notify health care provider/supervisor/LPN/RN to consider management and testing.

1. Do you have any of the following symptoms:	Yes	No
Fever		
Cough		
Shortness of Breath / Difficulty Breathing		
Runny Nose		
Sore throat		
Chills		
Painful / difficulty swallowing		
Hoarse voice		
Nasal congestion / stuffy nose		
Feeling unwell / fatigued / severe exhaustion		
Nausea / vomiting / diarrhea		
Unexplained loss of appetite		
Loss of sense of taste or smell		
Muscle / Joint aches		
Headache		
Conjunctivitis *(commonly known as pink eye)*		
Sneezing		
Altered Mental Status		
2. Have you travelled outside of Canada in the last 14 days ?		
3. Have you had close contact with a confirmed case of COVID-19 in the last 14 days? *(Face to face contact within 2 metres. A health care worker in an occupation setting wearing the recommended PPE is not considered to be a close contact.)*		
4. Have you had close contact with an individual who has any one of the first 5 **BOLDED** symptoms on this list: **fever, cough, shortness of breath/difficulty breathing, runny nose or sore throat** - AND who is a close contact of a confirmed case of COVID-19 in the last 14 days?		
5. Have you participated in an activity that would change your current risk level (*low, medium, high*)? Assess your personal risk of unknown exposure based on your last two weeks of activity *(refer to Risk of Unknown Exposure Checklist Form 21704)*		

Completed By	Date *(dd-Mon-yyyy)*