



## FAMILY VISITS SCREENING QUESTIONNAIRE

<b>Date:</b>
<b>Visitor's Name:</b>
<b>Resident's Name:</b>
<b>Telephone Number:</b>

**PLEASE COMPLETE ALL QUESTIONS BELOW:**

**1. Do you have any of the following symptoms?**

- fever/feverish (temperature 37.8 C or greater)
- new/worsening cough, shortness of breath, difficulty breathing, sore throat, runny nose or sneezing, nasal congestion, hoarse voice, difficulty swallowing, new olfactory or taste disorder(s), nausea, vomiting, diarrhea, abdominal pain
- Clinical or radiological evidence of pneumonia

Yes       No

**2. Have you had close contact with a person with acute respiratory illness who has been outside Canada in the last 14 days?**

Yes       No

**3. Have you travelled outside Canada in the last 14 days?**

Yes       No

**TEMPERATURE IN:** \_\_\_\_\_ **TEMPERATURE OUT:** \_\_\_\_\_

**SIGNATURE:**

---