Hope House
COMMUNITY HOSPICE
Formerly Hospice King-Aurora-Richmond Hill

COVID-19 Screening Document

FOR CLIENTS, FAMILIES, VOLUNTEERS & STAFF

Prior to in-person meetings, you must answer "NO" to the following questions:

1. Do you have any of the following NEW or WORSENING symptoms or signs? *(Symptoms should not be chronic or related to other known causes or conditions)*

Symptom		
Fever &/or chills (temp 37.8 degrees C or higher)	☐ Yes	☐ No
Shortness of breath (out of breath, can't breathe deeply)	☐ Yes	☐ No
Cough or barking cough (continuous, more than normal	☐ Yes	☐ No
Sore throat (painful swallowing)	☐ Yes	☐ No
Runny/stuffy/congested nose (not related to cold weather or allergies)	☐ Yes	☐ No
Decrease or loss of smell or taste	☐ Yes	☐ No
Nausea, vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Muscle aches that are unusual or long lasting	☐ Yes	☐ No
Pink Eye	☐ Yes	☐ No
Headache that's unusual or long lasting	☐ Yes	☐ No

2. Has a doctor, healthcare provider, public health unit told you that you should currently be isolating/staying at home? ☐ Yes ☐ No

3. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19 by a public health unit? ☐ Yes ☐ No

4. Is anyone you live with currently experiencing any COVID-19 symptoms &/or waiting for test results after experiencing symptoms ? ☐ Yes ☐ No

If you answered NO to all questions, you can proceed

If you have answered YES to any questions, you should not proceed