COVID-19 Screening Questionnaire

This questionnaire is designed for the safety of you and the clinic staff. If you, or anyone accompanying you, have a chance of currently being infected with coronavirus, you should delay your attendance until a safer time and we may advise this.

Patient details:

Name: ………………………………………………………………………… DOB: ………………………………………

Please answer as honestly as possible:

Does the patient or **any member of the household** have or has had symptoms suggestive of COVID-19 in the last two weeks:

New cough	☐ Yes	☐ No
Fever or chills	☐ Yes	☐ No
Breathlessness	☐ Yes	☐ No
Loss of smell and/ or taste	☐ Yes	☐ No

Are you 'shielding' or considered to be in a vulnerable group for Covid-19?

☐ Yes ☐ No

If yes, please give further details:

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If you are being accompanied by someone, do they have any of the above symptoms:

☐ Yes ☐ No

If yes, please give further details:

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Declaration:

I declare that the information given above is correct to the best of my knowledge and we will inform the clinic immediately if anything changes between now and the next appointment:

Name of person completing this form: ……………………………………………………………………………

Signed: ………………………………………………………………… Date: ………………………………………………

Please email this form to watfordortho.dental1@nhs.net. We will not accept paper forms.