

# COVID-19

## Screening Questions for Clients/Patients

Canadian Association of Clinical Thermography (CACT) requires all member clinics to screen every client / patient attending an in person appointment.

If you answer "yes" to any of the following questions, we cannot see you for an in-person appointment until you no longer present with any of these symptoms.

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

Yes  No

**2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?**

Yes  No

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

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Fever  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • New onset of cough                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Worsening chronic cough                                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Shortness of breath                                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Difficulty breathing                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Sore throat  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Difficulty swallowing                                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Decrease or loss of sense of taste or smell              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Chills   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Headaches  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Unexplained fatigue/malaise/muscle aches (myalgias)      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Nausea/vomiting, diarrhea, abdominal pain                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Pink eye (conjunctivitis)                                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Runny nose or nasal congestion without other known cause |

**4. If you are 70 years of age or older, are you experiencing any of the following symptoms?**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Delirium                                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Unexplained or increased number of falls |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Acute functional decline                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | • Worsening of chronic conditions          |

**5. Have you taken a COVID vaccine (of any type) within the past 14-days? (If yes, we may need to reschedule your appointment. Individuals post-vaccination may have swollen lymph nodes.**

Yes  No

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### COVID-19 Screening Results

- your responses to ALL of the screening questions is NO: You have screened "Negative and may attend your appointment
- If your response to ANY of the screening questions is YES: You have screened "Positive" should self-isolate and get tested