Dr. Bryan Friedmann
OPTOMETRIST

COVID-19 SCREENING FORM

Patient Legal Name: ______________________ **Birthdate**: M/D/Y ______________

Question		
Have you been tested positive for COVID-19 in the last 14 days?	**YES**	**NO**
Are you awaiting results for a COVID-19 test?	**YES**	**NO**
Do you have a fever over 37.5 degrees Celsius or chills?	**YES**	**NO**
Do you have a new or worsening cough?	**YES**	**NO**
Do you have a sore throat?	**YES**	**NO**
Do you have a runny nose or nasal congestion that you wouldn't normally have because of seasonal allergies or another pre-existing condition?	**YES**	**NO**
Do you have shortness of breath or difficulties breathing?	**YES**	**NO**
Do you have other cold or flu-like symptoms?	**YES**	**NO**
Are you feeling fatigued without explanation?	**YES**	**NO**
Have you experienced a recent loss of taste or smell?	**YES**	**NO**
Do you have new or worsening headache?	**YES**	**NO**
Do you have nausea, vomiting, diarrhea, or abdominal pain?	**YES**	**NO**
Even if you do not currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	**YES**	**NO**
In the past 14 days, have you been in close contact with any suspected or confirmed COVID-19 patients?	**YES**	**NO**
Have you been asked to self-isolate due to risk of exposure to COVID-19?	**YES**	**NO**
Have you returned from travel outside of the province in the past 14 days?	**YES**	**NO**

Please answer YES to mark your understanding on consent to the following statements:

Statement	
I understand that due to the frequency of visits by other patients, the characteristics of COVID-19, and the characteristics of eye exams where physical distancing is not possible, I have an elevated risk of contracting COVID-19 by being in an optometric office.	**YES**
I understand that the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not due to the limits in virus testing.	**YES**

By completing and submitting this survey, I knowingly and willingly consent to have Dr. Friedmann provide me with optometric care in his clinic during the COVID-19 pandemic.

Patient Signature ______________________________ **Date** ______________