Name of the person tracked down:_____ **Please indicate if the above name matches the patient or attendant screening form:** ☐ Patient ☐ Accompanying person - Patient's Name:_____	**PRE-APPOINT.** **Date:**	**CLINICAL** **Date:**
1-Have you had a positive COVID-19 test for less than 21 days or are you waiting for a screening test?	**Yes☐ No☐**	**Yes☐ No☐**
Present yourself with the following conditions:		
2-Fever (over 38 degrees Celsius or 100.4 degrees Fahrenheit)	**Yes☐ No☐**	**Yes☐ No☐**
3-Recent or chronic cough that has worsened	**Yes☐ No☐**	**Yes☐ No☐**
4-Respiratory difficulty (e.g., shortness of breath or difficulty speaking)	**Yes☐ No☐**	**Yes☐ No☐**
5-Sudden loss of smell (with or without loss of taste)	**Yes☐ No☐**	**Yes☐ No☐**
6-Muscle pain, headache, severe fatigue or significant loss of appetite	**Yes☐ No☐**	**Yes☐ No☐**
7-Throat sickness	**Yes☐ No☐**	**Yes☐ No☐**
8-Diarrhea	**Yes☐ No☐**	**Yes☐ No☐**
9-Have you been in close contact (at least 15 minutes within 2 metres) with a confirmed or probable case of COVID-19?	**Yes☐ No☐**	**Yes☐ No☐**

Signing of the person who filled out the form (patient or office staff):

Pre-appointment signature: _____**Clinical signature:** _____

THIS SECTION IS RESERVED FOR DENTAL CLINIC STAFF

If the patient replied:

- *YES to question 1: SUSPECTED/CONFIRMED STATUT.*
- *YES to at least one of the questions 2 to 5* ***AND*** *YES* to *question 9: SUSPECTED/CONFIRMED STATUT.*
- *YES to at least two of the questions 6 to 8* ***AND*** *YES* to *question 9: SUSPECTED/CONFIRMED STATUT.*
- *Any other answer: ASYMPTOMATIC STATUT.*

Check the box below corresponding to the patient's COVID-19 status.

☐ **Asymptomatic** ☐ **Suspected/Confirmed**

If the patient is considered to be suspected/confirmed COVID-19, consult the dentist before assigning an appointment.