Pre-Screening Questionnaire

If you or your client has flu like symptoms or are not feeling well

STOP

Call the office immediately

	Employee		Client	
1. Do you or someone in your home have **2 or more** of the following new or worsening symptoms... - Fever - Cough - Headache - Sore Throat - Runny Nose - Pain Swallowing - Loss of appetite – Onset of muscle aches – Unusual Fatigue or lack of energy - Diarrhea - Small red spots on hands or feet - Loss of sense of smell or taste	**YES** __ **NO** __		**YES** __ **NO** __	
2. Have you, or any household member, been in close contact with a known or suspected case of COVID-19 in the last 14 days?	**YES** __ **NO** __		**YES** __ **NO** __	
3. Have you, or have you been in contact with someone who has travelled outside the Atlantic Bubble within the last 14 days who has developed COVID-19 symptoms?	**YES** __ **NO** __		**YES** __ **NO** __	
If you or your client answered 'YES' to any questions above				
**** DO NOT GO TO WORK – *Contact the office immediately* ****				
Did the person complete the On line Self Assessment?	**YES** __ **NO** __		**YES** __ **NO** __	
Was the person instruct to Self-isolating or get tested?	**YES** __ **NO** __		**YES** __ **NO** __	
Have you advised the office?	**YES** __ **NO** __		**YES** __ **NO** __	

Completed by: _____ **Client Initials:** ___ **Date:** _____

*** To be completed by Home Support staff at the start of each shift. ***

Staff are required to ask Client questions prior to entering home.

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