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 any of the below new or worsening symptoms... - Fever - Cough - Headache - Sore Throat - Runny Nose - Pain Swallowing - Loss of appetite – Diarrhea - Small red spots on hands or feet - Loss of sense of smell or taste	**YES** __	**NO** __	**YES** __	**NO** __
2. In the last 14 days, have you been in close contact with a known or suspected case of COVID-19?	**YES** __	**NO** __	**YES** __	**NO** __
3. Have you received a notification from the COVID Alert app that you may have been exposed to COVID-19?	**YES** __	**NO** __	**YES** __	**NO** __
4. Are you currently self-isolating for any of the following reasons: Travel Regulations, Public Health Advisory, as directed by Public Health	**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 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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