FRASERVIEW RETIREMENT COMMUNITY

LTC COVID-19 ENHANCED VISITOR/VENDOR SCREENING QUESTIONAIRE

VISITORS/VENDORS WHO HAVE BEEN AWAY FROM THE FACILITY FOR MORE THAN 14 DAYS, MUST COMPLETE THIS FORM 72 HOUR PRIOR TO ENTERING THE FACILITY AND SUBMIT IT TO DIRECTOR OF CARE/ADMINISTRATOR

Name: Alex Collins

Date of first planned visit: August 19, 20

1. Have you ever been diagnosed with COVID-19?
   - ☐ Yes
   - ☑ No
2. In the last 14 days, to your knowledge, have you been in contact with anyone with COVID-19?
   - ☐ Yes
   - ☑ No
3. In the last 14 days, did you visit at a facility experiencing an outbreak of COVID-19?
   - ☐ Yes
   - ☑ No
4. Please list all healthcare facilities you have visited in during the last 14 days

_____

If **YES to any of the above,** notify their Director of Care/Administrator and call 811 for an assessment. **You will not be permitted to enter facility until cleared by Public Health.**
If NO, proceed with question #5

5. Do you have any of the following symptoms?
   - ☐ Fever
   - ☐ Diarrhea
   - ☐ Loss of taste or smell

If **YES to any of these symptoms**, please go to a testing site. **You will not be permitted to enter facility to visit until cleared by Public Health.**
If NO, proceed with question #6

6. Do you have any of the following symptoms?
   - ☐ Cough
   - ☐ Loss of appetite/ nausea
   - ☐ Muscle ache/fatigue
   - ☐ Runny nose/congestion
   - ☐ Headache
   - ☐ Sore throat
   - ☐ Other symptoms of a cold

If **YES to any of these symptoms,** please go to a testing site and/or call 811.
If NO, proceed with your shift or for the previously scheduled purpose you are in the building.

I certify that the above is true to the best of my knowledge.

Signature: _____

Date: August , 2020

DOC/Administrator Name: _____

DOC/Administrator Signature: _____

Date: _____