Resident Daily Screening Questionnaire

This screener is be completed as a self-check by all residents for signs of COVID-19. For any resident unable to complete a self-check, staff must complete the questionnaire for any resident who has routine interface with staff (e.g. personal care) at least **once** daily. Documentation of screening must be kept in the resident chart.

In addition, any resident leaving the site **must** be screened at re-entry. Screening **must** include temperature check using a non-invasive infrared or similar device.

Please complete the following COVID-19 Resident Questionnaire:

1.	Do you/Does the resident have any of the following symptoms:	**CIRCLE ONE**	
	• Fever (37.8 degrees Celsius or higher)	YES	NO
	• Any **new** or **worsening** respiratory symptoms:		
	o Cough	YES	NO
	o Shortness of Breath / Difficulty Breathing	YES	NO
	o Runny Nose or sneezing	YES	NO
	o Nasal congestion/Stuffy Nose	YES	NO
	o Hoarse voice	YES	NO
	o Sore throat/Painful Swallowing	YES	NO
	o Difficulty swallowing	YES	NO
	Any **new onset** atypical symptoms including but not limited to:		
	• Chills	YES	NO
	• Muscle/Joint Aches	YES	NO
	• Nausea / Vomiting / Diarrhea / Unexplained Loss of Appetite	YES	NO
	• Feeling unwell / Fatigued / Severe Exhaustion	YES	NO
	• Headache	YES	NO
	• Loss of Sense of Smell or Taste	YES	NO
	• Conjunctivitis	YES	NO
	• Altered Mental Status	YES	NO

Operators must be aware of, and follow, any applicable privacy legislation (e.g., Freedom of Information and Protection of Privacy Act, Health Information Act, Personal Information Protection Act, etc.), should they document/retain the Health Assessment Screening completed with residents and staff (or others).
If any resident answers YES to any question, the individual shall immediately be isolated in the facility.

Completed By: _____

Date: _____