Bush Park Dental

Covid-19 Triage. Name:_____

Do you, to your knowledge, currently have Covid-19? Yes ☐ No ☐

Have you previously been infected with Covid-19? Yes ☐ No ☐

If Yes, have you now tested negative with a nasopharyngeal swab test? Yes ☐ No ☐

If yes, when did you last have symptoms? Date: ___/_____/____

Do you live with someone who is currently self-isolating? Yes ☐ No ☐

Do you currently have or have had in the past 14 days any of the following symptoms?

Yes ☐ No ☐

Tick the symptoms if you answered Yes.

Temperature – do you feel hot to touch on your chest or back? ☐

Cough ☐ Cold or flu like symptoms ☐ Difficulty breathing ☐

Sore throat ☐ Shortness of breath ☐ Wheezing ☐

Muscle pains ☐ Loss of taste or smell ☐

Have you come into contact with someone confirmed with Covid-19 in the past 14 days?

Yes ☐ No ☐

In the last 14 days have you had close contact with at least 2 people with documented experience of fever or respiratory problems? Yes ☐ No ☐

Have you been part of any mass gatherings or had close contact with many unacquainted people?

Yes ☐ No ☐

Are you in pain? Yes ☐ No ☐ Pain from 1-10, 10 being the worst pain? .....

How long have you been experiencing the pain? .....

Bleeding? ☐ Swelling? ☐ Trauma? ☐

Additional details:

Signed: Date:

Reviewed by: Action taken: