Dr. Gail J. Chow Inc.

WELLNESS SCREENING FORM

1. Do you presently have a fever, or had a fever in the last two weeks?
2. Do you have any of these symptoms: cough, difficulty breathing, sore throat, new loss of smell or taste
3. Have you been in contact with any confirmed COVID-19 positive individuals, or anyone self-isolating because of a determined risk for COVID-19?
4. Have you returned from travel outside of Canada in the last 14 days?
5. Have you returned from travel within Canada from a location known to be affected with COVID-19?

If you have answered "yes" to any of the above, please contact the office 604-734-2536 to reschedule your appointment.

Have you returned from travel within Canada?

Are you currently waiting for a COVID-19 test result?

Have you received a positive COVID-19 test result within the past two weeks?

Name: _____

Signature: _____

Date: _____