

RESPIRATORY SYMPTOM & EXPOSURE QUESTIONNAIRE

DATE (dd/mm/yy)	CURRENT TIME (24 hr.)	NAME OF INDIVIDUAL	DATE OF BIRTH
■ / ■ / ■	■	■	■ / ■ / ■

This questionnaire, the Respiratory Symptom & Exposure Questionnaire (RSEQ), is to ascertain (as best as possible) if an individual poses a risk to others by way of respiratory infectious disease transmission. If any question is answered YES in either section (Symptom &/or Exposure Reporting) or, if an individual is febrile (higher than >38°C), or if an individual's SpO₂ reading is below 93%, the patient is to be considered High Risk Category and requires immediate secondary screening.

DIAGNOSTICS REPORTING (CURRENT)

TEMPERATURE	TIME ■:■	■°C	<input type="checkbox"/> ORAL	<input type="checkbox"/> AXILLA	<input type="checkbox"/> TYMPANIC	<input type="checkbox"/> INFRARED
OXYGEN SATURATION (SpO ₂)	TIME ■:■	■%				
IMMUNIZATION STATUS	<input type="checkbox"/> FULLY IMMUNIZED (>14 DAYS)	<input checked="" type="checkbox"/> PARTIALLY IMMUNIZED	<input checked="" type="checkbox"/> NO IMMUNIZATION			

IS THE INDIVIDUAL CURRENTLY &/OR HAS THE INDIVIDUAL EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST 14 DAYS?

SYMPTOM REPORTING	NO	YES	MILD	MODERATE	SEVERE	DATE OF ONSET (dd/mm/yy)	TIME OF ONSET (24 hr.)
	FEVER REDUCING MEDICATION USE?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	TIME ■:■	DOSE ■ MG	DRUG NAME ■	■ / ■ / ■
FEVER	<input type="checkbox"/>	<input checked="" type="checkbox"/>				■ / ■ / ■	■:■
FEELING FEVERISH &/or CHILLS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
NEW or WORSENING CHRONIC COUGH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
SHORTNESS OF BREATH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
HEADACHE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
DIMINISHED SMELL &/or TASTE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
MUSCLE &/or BODY ACHES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
FATIGUE &/or WEAKNESS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
SORE THROAT	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
DIARRHEA &/or VOMITING	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■
NASAL CONGESTION	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	■ / ■ / ■	■:■

NON-FULLY IMMUNIZED INDIVIDUALS:

DOES THE INDIVIDUAL MEET ANY OF THE CRITERIA BELOW?

EXPOSURE REPORTING	NO	YES
TRAVELLED OUTSIDE OF CANADA WITHIN THE LAST 14 DAYS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
HAD CONTACT WITH A CONFIRMED OR POSSIBLE CASE OF COVID-19 WITHIN THE LAST 14 DAYS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BEEN ADVISED BY A HEALTH AUTHORITY TO ISOLATE	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BEEN TESTED OR IN CONTACT WITH SOMEONE WHO HAS BEEN TESTED FOR COVID-19 WITHIN THE LAST 14 DAYS	<input type="checkbox"/>	<input checked="" type="checkbox"/>