

DR. TAMMY BRAUNER and DR. DAVE BRAUNER

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COVID-19 SCREENING QUESTIONNAIRE

Patient name: _____ Date: _____

PLEASE READ AND INITIAL NEXT TO THE FOLLOWING STATEMENTS.

If you cannot positively affirm to all of these questions you will be asked to clarify/postpone your appointment to a later date.

_____ I do not currently, nor have had in the last two weeks, a fever, cough,
Initial sore throat, felt ill, runny nose, shortness of breath, or any other
symptoms related to COVID-19.

_____ To the extent of my knowledge, I do not have, nor have I been in direct
Initial contact with someone who has confirmed diagnosis of COVID-19, nor
been around anyone experiencing symptoms as described above.

_____ Neither I, nor anyone living in my immediate household, have traveled
Initial outside of the country in the last 14 days.

Signature: _____

I hereby acknowledge that I have agreed to meet with the Service Provider (Terra Vision Care) at the Facility for the purpose of receiving optometric services (the "Services"). By agreeing to meet the Service Provider and receive the Services, I am aware of the following:

1. There is a risk that I could be exposed to severe acute respiratory syndrome coronavirus 2, the virus responsible for COVID-19 (hereinafter referred to as "COVID 19") while attending at the Facility to receive the Services. I accept and acknowledge that I could be exposed to COVID 19 through the following means (this list is not exhaustive):

- a. My physical presence at the Facility;
- b. My interactions with other patients or members of the public who are present at the Facility at the time of my attendance;
- c. My interactions with staff, agents and other health care professionals at the Facility; and
- d. The physical touching of any equipment, items or fixtures in the Facility.

2. While receiving services, the Service Provider may need to be physically closer to me than the recommended social distancing guidelines in order to assess and/or treat me.

I acknowledge that I have read and fully understand the risks as described above. I acknowledge and confirm that I am willing to accept these risks as a condition of attending at the Facility to receive the Services from the Service Provider.

I confirm that any questions that I had regarding the provision of the Services during the COVID 19 pandemic have been answered by the Service Provider.

Signature: _____