

ADHA Interim Guidance for Dental Hygiene Practice During the COVID-19 Pandemic

In order to protect the dental hygienist, the dental team and patients, the American Dental Hygienists' Association (ADHA) continues to support the recommendations from the Centers for Disease Control and Prevention (CDC) that balance the need to provide necessary services while minimizing risk to patients and dental healthcare personnel (DHCP). [All healthcare personnel are recommended to get vaccinated against COVID-19.](#) Unvaccinated DHCP, patients and visitors should be [offered resources and counseled](#) about the importance of receiving the COVID-19 vaccine. No team members should come to work if sick or having cold, flu or COVID-19 symptoms.

Postpone all non-urgent dental treatment for: 1) patients with suspected or confirmed SARS-CoV-2 infection until they meet criteria to discontinue [Transmission-Based Precautions](#) and 2) patients who meet criteria for quarantine until they complete quarantine.

- Dental care for these patients should only be provided if medically necessary. Follow all recommendations for care and placement for patients with suspected or confirmed SARS-CoV-2 infection.
- If a patient has a fever strongly associated with a dental diagnosis (e.g., pulpal and periapical dental pain and intraoral swelling are present) but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended for routine health care during the pandemic.

ADHA has developed this document to provide ongoing interim guidance to dental hygienists during the pandemic.

As licensed health care providers, dental hygienists have a responsibility to uphold the highest standards of clinical practice to ensure the health and safety of the individuals they serve and the team members with whom they interact.

The following considerations have been prepared utilizing guidelines, regulations and resources from key resources including, but not limited to, CDC, the Occupational Safety and Health Administration (OSHA), and the Organization for Safety, Asepsis and Prevention (OSAP).

ADHA recommends that all dental hygienists follow the [Standards for Clinical Dental Hygiene Practice](#), which state that dental hygienists “follow the most current guidelines to reduce the risks of health-care-associated infections in patients and illnesses and injuries in health care personnel.”

It is also recommended that all dental hygienists review the [ADHA Code of Ethics](#) and verify that their individual malpractice insurance is current.

DHCP should stay informed and regularly consult with the [state or local health department](#) for region-specific information and recommendations. [Monitor trends](#) in local case counts and deaths, especially for populations at higher risk for severe illness.

Consult with local public health authority and state officials to determine COVID-19 prevalence and risk level.

Communication within the Dental Team

Meet with your employer and the entire dental team to have an open conversation about:

- Current supply of PPE and new supplies needed
- Screening practice for COVID-19
- Methods to reduce/eliminate aerosol production in the office
- Strategies for social distancing among patients and the dental team
- Scheduling changes for providers to allow for appropriate disinfecting between patients

Identify one team member who will regularly monitor national resources and update the entire dental team on key recommendations that will impact practice, including ADHA’s [COVID-19 Resource Center](#).

Conduct an inventory of PPE and other infection-control supplies.

Work Environment

The Occupational Safety and Health Administration (OSHA) issued an “emergency temporary standard” (ETS) following an executive order signed by President Joe Biden in January 2021 directing OSHA to consider a rule that would require employers to take steps to protect workers from contracting COVID-19 while on the job. This ETS focuses exclusively on the health-care industry.

The ETS does NOT apply to “non-hospital ambulatory care settings [i.e. dental settings] where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings.”

While the ETS may not apply to many settings where dental healthcare personnel work, it does include important information that can be implemented in any health care setting, including dental settings:

- Develop and implement effective COVID-19 plans. Controlling COVID-19 requires employers to use multiple overlapping controls in a layered approach to better protect workers.
- Have a designated safety coordinator with authority to ensure compliance, a workplace-specific hazard assessment, involvement of non-managerial employees in hazard assessment and plan development/implementation, and policies and procedures to minimize the risk of transmission of COVID-19 to employees.
- Limit and monitor points of entry to settings where direct patient care is provided; screen and triage patients, clients, and other visitors and non-employees; implement patient management strategies.
- Develop and implement policies and procedures to adhere to Standard and Transmission-Based precautions based on CDC guidelines.
- Provide and ensure each employee wears a facemask when indoors and when occupying a vehicle with other people for work purposes; provide and ensure employees use respirators and other PPE for exposure to people with suspected or confirmed COVID-19, and for aerosol-generating procedures on a person with suspected or confirmed COVID-19.
 - Employees should change facemasks at least once per day, whenever they are soiled or damaged, and more frequently as necessary (e.g., patient care reasons)

Resources:

- [ETS Regulatory Text \(29 CFR 1910, Subpart U\)](#)
- [Fact Sheet: Subpart U—COVID-19 Healthcare ETS](#)
- [Is your workplace covered by the COVID-19 Healthcare ETS?](#)
- [Frequently Asked Questions](#)

Recommended Routine Infection Prevention and Control (IPC) Practices

- Ensure everyone is aware of recommended IPC practices in the facility.
 - Post visual alert (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.

- Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) [symptoms of COVID-19](#), or 3) who meets criteria for [quarantine](#) or [exclusion from work](#).
 - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
- Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility. Recommendations for evaluation and work restriction of these HCP are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)
- Visitors meeting any of the 3 above criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively.
- CDC has updated four parts of the Epidemiology and Control of Selected Infections section of the Guideline for Infection Control in Healthcare Personnel, originally published in 1998. This guideline is intended for use by leaders and staff of Occupational Health Services (OHS) and to guide OHS in the management of exposed or infected healthcare personnel (HCP) who may be contagious to others in the workplace. [Updated Guidelines](#)



Hygiene

- Take steps to ensure patients and staff adhere to respiratory hygiene and cough etiquette, as well as hand hygiene, and all patients follow triage procedures throughout the duration of the visit.
 - Post [visual alerts](#) (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, break rooms) to provide instructions (in appropriate languages) about hand hygiene and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
 - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with at least 60% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
 - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
- Place chairs in the waiting room at least six feet apart.
- Remove toys, magazines, and other frequently touched objects from waiting room that cannot be regularly cleaned and disinfected.

- Minimize the number of persons waiting in the waiting room.
 - Patients may opt to wait in a personal vehicle or outside the dental facility where they can be contacted by mobile phone when it is their turn for dental care.
 - Minimize overlapping dental appointments.

Office Protocols

- Set up operatories so that only the clean or sterile supplies and instruments needed for the dental procedure are readily accessible. All other supplies and instruments should be in covered storage, such as drawers and cabinets, and away from potential contamination. Any supplies and equipment that are exposed but not used during the procedure should be considered contaminated and should be disposed of or reprocessed properly after completion of the procedure.
- Maintain six-foot social distancing at work with other team members and patients when not performing treatment.
- Determine the maximum number of patients who can safely receive care at the same time in the dental facility, based on the number of rooms, the layout of the facility, and the time needed to clean and disinfect patient operatories.

Patient Preparation

Patient Management

- Contact all patients prior to dental treatment.
 - [Telephone screen*](#) all patients for [symptoms consistent with COVID-19](#). If the patient reports symptoms of COVID-19, avoid non-emergent dental care. If possible, delay dental care until the [patient has recovered](#).
 - Assess the patient's dental condition and determine whether the patient needs to be seen in the dental setting. Use teledentistry options as alternatives to in-office care.
 - Request that the patient limit the number of visitors accompanying the patient to the dental appointment to only those people who are necessary.
 - Advise patients that they, and anyone accompanying them to the appointment, will be requested to wear a face covering when entering the facility and will undergo screening for fever and symptoms consistent with COVID-19.
- Systematically assess all patients and visitors upon arrival.
 - Ensure that the patient and visitors have donned their own face covering, or provide a surgical mask if supplies are adequate.

- Screen everyone entering the dental healthcare facility for fever and [symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection](#).
- Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.
- Document absence of symptoms consistent with COVID-19.
- Ask patient to re-don their face covering at the completion of their clinical dental care when they leave the treatment area.
- Even when DHCP screen patients for respiratory infections, inadvertent treatment of a dental patient who is later confirmed to have COVID-19 may occur. To address this, DHCP should request that the patient inform the dental clinic if they develop symptoms or are diagnosed with COVID-19 within 2 days following the dental appointment.*

Pre-screening of patients, using teledentistry, will reduce the number of in-office patients, as well as post-treatment follow-up appointments.

If forms need to be completed and signed, provide pens to the patients, and instruct them to keep the pens for their personal use.

*or teledentistry screen. Note: ADHA has added this amendment to the CDC guidance.

**Note: ADHA recommends the dental hygienist follow up with the patient 2 days post-appointment to ask if they have developed symptoms or have been diagnosed with COVID-19.

Special Considerations for Providing Dental Hygiene Care

Dental treatment should be provided in individual patient rooms whenever possible.

For dental facilities with open floor plans, to prevent the spread of pathogens there should be:

- At least 6 feet of space between patient chairs.
- Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
- Operatories should be oriented parallel to the direction of airflow if possible.
- Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.
- Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

Aerosol Generating Procedures

OSHA has defined aerosol-generating procedures as “a medical procedure that generates aerosols that can be infectious and are of respirable size. For the purposes of this section, only the following medical procedures are considered aerosol-generating procedures: open suctioning of airways; sputum induction; cardiopulmonary resuscitation; endotracheal intubation and extubation; non-invasive ventilation (e.g., BiPAP, CPAP); bronchoscopy; manual ventilation; medical/surgical/postmortem procedures using oscillating bone saws; and dental procedures involving: ultrasonic scalers; high-speed dental handpieces; air/water syringes; air polishing; and air abrasion”.

- When performing aerosol generating procedures on patients who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that DHCP correctly wear the recommended PPE (including a NIOSH-approved N95 or equivalent or higher-level respirator in counties with substantial or high levels of transmission) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols.
 - Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.
- High-volume evacuators (HVE) should be available in dental hygiene rooms, and a dental hygiene assistant should be available during procedures that require HVE. The room should be properly sanitized after all procedures.
 - Use full-mouth rubber dams for placement of dental sealants and during dental therapy restorative treatment.
- Backflow can occur when using a saliva ejector; therefore, when possible, use four-handed technique and HVE for controlling aerosols and splatter.

Preprocedural Mouth Rinse

- There is no published evidence regarding the clinical effectiveness of Preprocedural Mouth Rinse (PPMR) to reduce SARS-CoV-2 viral loads or to prevent transmission. Although COVID-19 was not studied, PPMRs with an antimicrobial product (chlorhexidine gluconate, essential oils, povidone-iodine or cetylpyridinium chloride) may reduce the level of oral microorganisms in aerosols and spatter generated during dental procedures.

Personal Protective Equipment (PPE)

For DHCP working in facilities located in areas with no to minimal community transmission

- DHCP should continue to adhere to Standard Precautions (and Transmission-Based Precautions, if required based on the suspected diagnosis).

- DHCP should wear a surgical mask, eye protection (goggles or a face shield that covers the front and sides of the face), a gown or protective clothing, and gloves during procedures likely to generate splashing or spattering of blood or other body fluids. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

For DHCP working in facilities located in areas with moderate to substantial community transmission

- DHCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), DHCP should follow Standard Precautions (and Transmission-Based Precautions, if required based on the suspected diagnosis).
- DHCP should implement the use of universal eye protection and wear eye protection in addition to their surgical mask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
- During aerosol generating procedures DHCP should use a NIOSH certified N95 respirator or a respirator that offers an equivalent or higher level of protection such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), or elastomeric respirators.
 - Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the [Occupational Safety and Health Administration's \(OSHA\) Respiratory Protection standard \(29 CFR 1910.134\)](#).

PPE Considerations for Extended Use

CDC has developed a series of strategies or options to optimize supplies of PPE in healthcare settings when there is limited supply, and a burn rate calculator that provides information for healthcare facilities to plan and optimize the use of PPE for response to the COVID-19 pandemic. Optimization strategies are provided for gloves, gowns, facemasks, eye protection, and respirators.

These policies are only intended to remain in effect during times of shortages during the COVID-19 pandemic. DHCP should review this guidance carefully, as it is based on a set of tiered recommendations. Strategies should be implemented sequentially. Decisions by facilities to move to contingency and crisis capacity strategies are based on the following assumptions:

- Facilities understand their current PPE inventory and supply chain;
- Facilities understand their PPE utilization rate;

- Facilities have already implemented engineering and administrative control measures;
- Facilities have provided DHCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care.

For example, extended use of facemasks and respirators should only be undertaken when the facility is at contingency or crisis capacity and has reasonably implemented all applicable administrative and engineering controls. Such controls include selectively canceling elective and non-urgent procedures and appointments for which PPE is typically used by DHCP. Extended use of PPE is not intended to encourage dental facilities to practice at a normal patient volume during a PPE shortage, but only to be implemented in the short term when other controls have been exhausted. Once the supply of PPE has increased, facilities should return to conventional strategies.

Respirators that comply with international standards may be considered during times of known shortages. CDC has guidance entitled [Factors to Consider When Planning to Purchase Respirators from Another Country](#).

Respirators

The following best practice recommendations are advised using these key terms:

- Critical tasks – all functions that occur during clinical treatment
- Non-critical tasks – procedures such as cleaning the operatory, sterilizing instruments, bringing supplies to/from the operatory

Best practice for respiratory protection involves the use of N95 respirators custom-fitted for critical tasks; training on fit and seal should be provided prior to use. Other masks may be used for non-critical tasks. Remove the respirator after every patient.

Fit-test kits are available commercially. Carefully follow manufacturer instructions.

Respiratory fit testing

- can be done by employer or outside party,
- should be done annually thereafter, and
- uses an agent to check whether there is leakage around the respirator.

Surgical masks are to be discarded after exiting the patient's room or care area and closing the door (if present). Take into consideration that most dental procedures generate droplets, spatter and aerosols.

- Remove and discard disposable respirators and surgical masks.
- Perform hand hygiene after removing the respirator or face mask.

Resources:[CDC Illustration of COVID-19 PPE for Health Care Personnel](#)

[Hospital Respiratory Protection Program Toolkit](#): Though designed for hospitals, the information in this resource from the Occupational Safety and Health Administration (OSHA) can be customized for your practice.

Donning and Doffing PPE

There are multiple [sequences recommended for donning and doffing PPE](#).

One suggested sequence for DHCP includes:

- Before entering a patient room or care area:
 1. Perform hand hygiene.
 2. Put on a clean gown or protective clothing that covers personal clothing and skin (e.g., forearms) likely to be soiled with blood, saliva, or other potentially infectious materials.
 - Gowns and protective clothing should be changed if they become soiled.
 3. Put on a surgical mask or respirator.
 - Mask ties should be secured on the crown of the head (top tie) and the base of the neck (bottom tie). If mask has loops, hook them appropriately around your ears.
 - Respirator straps should be placed on the crown of the head (top strap) and the base of the neck (bottom strap). Perform a user seal check each time you put on the respirator.
 4. Put on eye protection (goggles or a face shield that covers the front and sides of the face).
 - Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
 - Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
 5. Perform hand hygiene.
 6. Put on clean non-sterile gloves.
 - Gloves should be changed if they become torn or heavily contaminated.
 7. Enter the patient room.
- After completion of dental care:
 1. Remove gloves.
 2. Remove gown or protective clothing and discard the gown in a dedicated container for waste or linen.

- Discard disposable gowns after each use.
 - [Launder](#) cloth gowns or protective clothing after each use.
 - 3. Exit the patient room or care area.
 - 4. Perform hand hygiene.
 - 5. Remove eye protection
 - Carefully remove eye protection by grabbing the strap and pulling upwards and away from head. Do not touch the front of the eye protection.
 - Clean and disinfect reusable eye protection according to manufacturer's reprocessing instructions prior to reuse.
 - Discard disposable eye protection after use.
 - 6. Remove and discard surgical mask or respirator.
 - Do not touch the front of the respirator or mask.
 - Surgical mask: Carefully untie the mask (or unhook from the ears) and pull it away from the face without touching the front.
 - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - 7. Perform hand hygiene.
- Team members should leave their shoes at the office, and footwear should be disinfected daily.

Disinfection

Appropriate PPE should be worn for all activities involving potential exposure to patient body fluids, contaminated surfaces and equipment, and hazardous chemicals (e.g. disinfectants).

Puncture resistant/utility gloves, masks, eye protection and gowns should be worn while handling contaminated instruments.

Patients should be scheduled in a manner that allows for complete disinfection of operatories.

If possible, decide upon two rooms for each dental hygienist to use, so that one room can be sanitized and prepared while the dental hygienist begins using the next room for another patient.

If there is only one room dedicated for dental hygiene care, it is recommended to increase patient appointment time, e.g., 1.5 hours per appointment for appropriate disinfection and room preparation. Do not double-book appointments.

If there is no door for the operatory, consider using a plastic barrier to seal the room. This barrier will need to be disinfected between patients.

Barriers should be used when possible, especially for hard-to-clean surfaces (e.g. light switches, computer, mouse, dental unit) and changed between patients.

- DHCP should ensure that environmental cleaning and disinfection procedures are followed consistently and correctly after each patient (however, it is not necessary that DHCP should attempt to sterilize a dental operatory between patients).
 - Clean and disinfect the room and equipment according to the [Guidelines for Infection Control in Dental Health-Care Settings—2003](#).
 - To clean and disinfect the dental operatory after a patient with COVID-19, DHCP should delay entry into the operatory until a [sufficient time has elapsed](#) for enough air changes to remove potentially infectious particles.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to clean surfaces before applying an Environmental Protection Agency-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
 - Refer to [List N](#) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

Doors and knobs need to be wiped down in addition to counters, chairs, cabinets and other surfaces.

Designate clean and dirty areas in the sterilization area. Heat-sterilize all critical and heat tolerant reusable dental and dental hygiene instruments prior to use. Use chemical and biologic monitoring to ensure sterilization is effective. Keep all sterile instruments packaged until ready to be used for patient care. [Guidelines for Infection Control in Dental Health-Care Settings—2003](#)

[OSHA Guidance for Dentistry Workers and Employers](#)

COVID-19 Testing

- Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test as soon as possible.
- Asymptomatic HCP with a [higher-risk exposure](#) and patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. However, testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic; this is because some people may have detectable virus from their prior infection during this period (additional information is available [here](#)). Criteria for use of post-exposure prophylaxis are described

- Guidance for work restrictions for HCP with higher-risk exposures are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#).

- Performance of pre-procedure or pre-admission viral testing is at the discretion of the facility. The yield of this testing for identifying asymptomatic infection is likely low when performed on vaccinated individuals or those in counties with low or moderate transmission. However, these results might continue to be useful in some situations (e.g., when performing higher risk procedures on unvaccinated people) to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used).

Healthcare Worker Isolation and Quarantine Guidance



The CDC has provided interim guidance to assist with determining the duration of restriction from the workplace for HCP with SARS-CoV-2 infection and assessing the risk and application of workplace restrictions for asymptomatic HCP with exposure to SARS-CoV-2. In general:

- Healthcare workers with COVID-19 who are asymptomatic can return to work after 7 days with a negative test, and that isolation time can be cut further if there are staffing shortages.
- Healthcare workers who have received all recommended COVID-19 vaccine doses, including a booster, do not need to quarantine at home following high-risk exposures.

Further details are available at [CDC Potential Exposure at Work](#).

Create a Process to Respond to SARS-CoV-2 Exposures Among DHCP and Others

Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. Guidance on assessing the risk for exposed patients and HCP is available in the [Healthcare Infection Prevention and Control FAQs for COVID-19](#).

If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. For example, in an outpatient dialysis facility with an open treatment area, testing should ideally include all patients and HCP. Depending on testing resources available or the likelihood of healthcare-associated transmission, facilities may elect to initially expand testing only to HCP and patients on the affected units or departments, or a particular treatment schedule or shift, as opposed to the entire facility. If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days.

Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities.

ADHA COVID-19 PATIENT SCREENING QUESTIONNAIRE



*Indicate Yes or No and provide relevant comments.

Patient Name: _____

Date: _____

Screening Questions	Pre-Appointment*	In-Office*	Post-Appointment*
Have you received a COVID-19 vaccine? • Unvaccinated patients should be offered resources and counseled about the importance of receiving the COVID-19 vaccine. • This information should be noted in the patient’s health record.			
Do you have a fever, or have you felt feverish recently?			
Do you have a cough?			
Are you having shortness of breath or any difficulty breathing?			
Do you have chills or repeated shaking with chills?			
Do you have any muscle pain or body aches?			
Do you have any recent onset of headache or sore throat?			
Have you been experiencing nausea and/or vomiting?			
Do you have any recent loss of taste or smell?			
Have you been experiencing fatigue recently?			
Have you experienced any recent GI upset or diarrhea?			
Have you been advised to self-quarantine because of exposure to someone with COVID-19?			
Have you traveled in the past 14 days to any regions affected by COVID-19?			
Have you been tested for COVID-19? If yes, what was the result?			
Have you been diagnosed with COVID-19? If yes, when?			
Are you over the age of 65? Do you have: Heart disease Lung disease Kidney disease Diabetes Autoimmune disorders			

Dental hygienist follows up with the patient 2 days post-appointment to ask if they have developed symptoms or have been diagnosed with COVID-19.