COLLEGE OF MASSAGE THERAPISTS of Newfoundland & Labrador

COVID-19 Client Screening Checklist

A screening is strongly recommended to ensure a low risk environment for both clients and Therapists. This is a suggested screening and RMT's may make changes as long the minimum public health requirements are met. Vaccination status is not permitted on any screening tool.

COVID-19 Client Screening Questions

Client: _____ **Date: _____**

Question	Yes/No
Q1: Are you presenting with fever (or signs of a fever, including chills, sweats, muscle aches, light headedness), new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing?	
Q2: Do you have one (1) or more of the following symptoms: sore throat, runny nose/sneezing, nasal congestion, difficulty swallowing, decrease or loss of sense of smell, headaches, unexplained fatigue/malaise, diarrhea, abdominal pain, or nausea/vomiting?	
Q3: Do you have a confirmed case of COVID-19 or had close contact in the last 10 days with a confirmed active case of COVID-19 without the use of full PPE?	
Q4: Have you or a household member been directed to isolate by public health in the last 10 days?	

Therapist:_____

COVID-19 Screening Results

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If response to **ALL** of the screening questions is **NO**:	***Treat client with all necessary precautions***
If response to **ANY** of the screening questions is **YES**:	**Delay treatment** **Follow up questions may be needed**
If response to **ANY** of the screening questions is UNKNOWN:	**Delay treatment**

Notes:

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