

COVID-19 Screening Form

First point of contact should screen the patient/visitor and check any boxes that apply.

<input type="checkbox"/>	has a fever (>100.4) AND signs/symptoms of acute illness (e.g. cough, difficulty breathing, sudden loss of taste or smell, sore throat, body aches)
<input type="checkbox"/>	has had close contact with someone with confirmed or suspected COVID-19 within the last 14 days
<input type="checkbox"/>	has more than one symptom of acute illness (e.g. cough, difficulty breathing, sudden loss of taste or smell, sore throat, body aches)
<input type="checkbox"/>	does not meet any of the above criteria

VISITORS:

If any of the first three boxes are checked, the visitor should be advised to defer visiting the facility. If the visitor refuses, contact the administrator on call.

PATIENTS:

If any of the first three boxes are checked, place a mask on the patient and collect the following information.

Name _____ Phone _____ Date _____ Time _____

Send the patient to

following established routes.