PRE-SCREENING QUESTIONS FOR COVID-19

Date of Encounter: ________________

Time of Encounter: ________________

Patient Name: __________________________________

Date of Birth: ________________

Reason for Today's Visit: ____

Temperature: ____________

Question 1: Are you immunocompromised? Yes______ No______

- If Yes, you will be placed in a waiting area with decreased patient flow

Question 2: Have you been tested for the COVID-19 Virus: Yes______ No______

Question 3: Do you have NEW onset fever or symptoms of lower respiratory illness (cough, shortness of breath)? Yes______ No______

Explain if Yes:____
____

Question 4: Have you been in close contact with someone who is confirmed positive or symptomatic of Covid-19 for the last 14 days? Yes______ No______ Unsure: _____

Explain if Yes:____
____

If YES to Questions 2, 3, 4:

- Please make sure patient has surgical mask on and you have your mask on yourself.
- Do NOT allow the patient to wait in the general waiting area – take to the COVID holding area
- Notify supervisors and front line staff.

Signature: _________________________