COVID-19 Screening

We are striving to provide a safe environment for our patients and staff. Please answer the following questions which are in accordance with CDC guidelines. Thank you for helping us protect you and others during this time.

Patient Name:_____ Temp: _____/_____
Patient / Support Person

Questions	**Patient**	**Support Person**
1. Within the past 14 day, have you been in close physical contact (6ft or closer for >15 minutes) with: a. Anyone who is known to have laboratory confirmed COVID-19? Or b. Anyone who has symptoms consistent with COVID-19?	a. YES / NO b. YES / NO	a. YES / NO b. YES / NO
2. Within the last 10 days, have you had a positive COVID-19 test? a. Has it been <10 days since your symptoms first appeared? or b. Has it been <24 hours since your last fever (without use of fever reducing medications)?	2. YES / NO a. YES / NO b. YES / NO	2. YES / NO a. YES / NO b. YES / NO
3. Are you currently waiting on the results of a COVID-19 test?	YES / NO	YES / NO
4. Have you experienced any of the following symptoms in the past 48 hours: (If yes, please list) - Fever or Chills - Cough - Shortness of breath of difficulty breathing - Fatigue - Muscle or Body aches - Headache - New loss of sense of taste and smell - Sore throat - Congestion or runny nose - Nausea/Vomiting - Diarrhea	Symptoms:	Symptoms:

*** Please notify staff immediately if you answer YES to any of the questions above***