Novel Coronavirus (COVID-19) Screening Tool

Purpose: This tool is intended to assist with screening of visitors for the safety and protection of our patients and staff.

Please circle Yes or No to each question:

|  |  |  |
| --- | --- | --- |
| Do you have any of the below symptoms: |  |  |
| * Fever >100.4 F or feel feverish | Yes | No |
| * New cough | Yes | No |
| * New shortness of breath/breathing difficulties | Yes | No |
| * Other symptoms such as muscle aches, fatigue, headache, sore throat, or diarrhea. | Yes | No |
| Have you been around anyone who has been sick with cough and/or fever, and has traveled out of the country within the last 14 days? | Yes | No |
| Have you been around anyone in the last 14 days that is a confirmed case of COVID 19? | Yes | No |

If you answered **NO** to all questions, please sign and date for our records with your phone #

If you answered **YES** to any questions, please speak to the health screener.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room #:\_\_\_\_\_\_\_\_\_\_