**Patients Presenting to Office / Facility: COVID-19 Screening**

ALL individuals (staff, other health care workers, family, visitors, government officials, etc.)

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| **\_\_\_\_\_\_\_** | 1. | Do you have any of the following symptoms (check each symptom applicable) ?  **Y / N** Fever  **Y / N** Sore throat  **Y / N** Cough  **Y / N** New shortness of breath  **Y / N** Recent sensory loss of taste and/or smell **Y / N** Gastro symptoms (including: abdominal pain/cramping, nausea, diarrhea  and vomiting) |
| **Y / N** | 2. | Are you or any member of your household currently on a mandatory or self-quarantine? |
| **Y / N** | 3. | Have you or any member of your household been exposed or potentially exposed to  anyone who has tested positive to COVID-19? |
| **Y / N** | 4. | Have you or any member of your household in the past week had contact with any person(s)  that have traveled domestically and/or internationally in the past 3 weeks via commercial mode.  (i.e. Airplane, Bus, Train, Cruise Ship)? |
| **Y / N** | 5. | Have you or any member of your household been tested in the last 14 days for COVID-19? |
| **Y / N**  **Y / N** | 6.  6a. | Are you a Healthcare worker? *(If yes please answer 6a)*  Are you working on a COVID-19 floor? |

**I am aware that providing false answers or information regarding exposure and/or possible exposure, mandatory quarantine and/or self-quarantine is a criminal offense and reportable to law enforcement and/or governmental agencies monitoring the COVID-19 pandemic.**

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Patient’s Signature Patient’s Name (print) Date

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature recorded by staff \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCREENER INITIALS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If “YES” TO ANY ABOVE QUESTIONS

PROVIDER APPROVAL TO BE SEEN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MA OR PROVIDER INITIALS)