Coronavirus Patient Screening Tool

ATTN For Patients Prescreened via Phone Call: Patient denies fever or other respiratory symptoms, diarrhea, international travel, or close contact with anyone known to have 2019-nCOV:

- Since the prescreening call ☐ Yes ☐ No
- COVID-19 (SARS-CoV-2-RNA) testing since the prescreening call ☐ Yes ☐ No

Screener signature _____ **Date:** _____

If patient screens positive, notify the attending physician for **direction.**

Prescreen or Day of Visit Questionnaire

Previous COVID-19 (SARS-CoV-2-RNA) **Test:** ☐ Yes ☐ No **Results:** ☐ Positive ☐ Negative
Test date: _____ (month/day/year)

1. Are you experiencing any symptoms of respiratory illness, fever, chills, cough, difficulty breathing, shortness of breath, sore throat or GI symptom of diarrhea or new loss of taste or smell, headache or myalgia (muscle pain or muscle ache)?
   ☐ Yes (Circle symptoms reported) ☐ No
2. If yes, approximately how long ago did you first notice symptoms? _____ Hours
   _____ Days_____ Weeks
3. **Temperature at visit _____°F**
   In the past 14 days, have you traveled internationally? ☐ Yes ☐ No
4. If yes, where to? _____
5. In the past 14 days, have you had close contact with a person known to have 2019-nCOV (Coronavirus)? ☐ Yes ☐ No

Note: any positive response or temperature ≥100.4 °F, is considered a positive screening.

Inform patient if a mask is provided, it does not prevent spreading of the Coronavirus but is effective against the spread of the flu.

_____ _____ _____

(Print) Patient Name Screener Signature Date

Staff Only: Case Cancelled: ☐ Yes

Mask provided: ☐ Yes ☐ No Notified Public Health Department: ☐ Yes ☐ No

Patient Referred to: ☐ Primary Care Physician ☐ Emergency Room ☐ Public Health Department

☐ Urgent Care ☐ Other: _____