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COVID – 19 SCREENING FORM:

1) Do you have any symptoms of COVID – 19?

- **i.** These could include a fever, cough, sore throat, fatigue, loss of taste/smell, GI symptoms, or any other know COVID – 19 symptoms.
- **ii.** **Yes** ☐ **No** ☐
- **iii.** If yes, please describe the symptoms and when they started:

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2) Have you traveled to any areas of high risk for COVID – 19 in the last 2 weeks?

- **i.** Possible areas of high risk include travel out of the state, out of the country, to a hospital, nursing home, or other long-term care facility.
- **ii.** **Yes** ☐ **No** ☐
- **iii.** If yes, please describe where the person traveled to, and when the travel happened:

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3) Have you had any close contact (please refer below) with any person confirmed to have COVID – 19, or close contact with any person who had COVID – 19 symptoms in the last 2 weeks?

- **i.** Close contact is defined as person(s) within 6 feet (2 meters) or within the room/care area of a patient(s) with confirmed or probable COVID – 19
- **ii.** **Yes** ☐ **No** ☐
- **iii.** If yes, please describe when the contact occurred:

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Patient name:___________________________________ **Patient date of birth:**_________________________

_______________________________________ _______________________________________

Patient Signature **Today's Date**