COVID-19 SCREENING FORM

Patient Name:_____ **Patient's Date of Birth:** _____

1. **Has the patient been tested for COVID-19?** ☐ Yes ☐ No

   If **yes**, please indicate the date of **most recent** test: _____

   If **yes**, for the **most recent** test, was the result positive? ☐ Yes ☐ No

2. **For patients with a confirmed COVID-19 illness who are recovering from the illness, please indicate the following:**

   The patient has been **without** fever for at least 3-days (72-hours) **without** the use of fever-reducing medications:

   ☐ Yes ☐ No

   The patient has an improvement in respiratory symptoms (e.g., cough, shortness of breath):

   ☐ Yes ☐ No

   At least 7-days have passed since the patient's COVID-19 illness symptoms first appeared:

   ☐ Yes ☐ No

   The patient has a documented negative COVID-19 follow-up test:

   ☐ Yes ☐ No

   Date of negative follow-up test: _____

3. **Has the patient had direct contact with a person confirmed or suspected to be positive for COVID-19?**

   ☐ Yes ☐ No

4. **Is the patient currently (within past 72 hours) experiencing any of the following symptoms?**

   Fever >100.4 ☐ Yes ☐ No

   If **yes**, please detail the last 36-hours of temperature recordings:

Sore throat ☐ Yes ☐ No

Cough ☐ Yes ☐ No

Shortness of breath? ☐ Yes ☐ No

If **yes**, does the patient have a significant comorbidity (i.e., pulmonary conditions, cardiovascular disease, Diabetes Mellitus, immunosuppression, etc.)? If so, please detail:

Name of the Referring Agency: _____

Name and Contact Number of Referring Worker: _____

Date of Completion: _____ Time of Completion: _____

Signature of Referring Worker: _____

Updated 12.07.2020