PT#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| Today’s Date of Screening: \_\_\_\_\_\_\_\_\_\_\_ Time of Screening:  Signature of Office Screener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Decision of Entry: |
| Have you been tested positive with COVID-19? Yes or No  If YES, did you bring proof of two consecutive negative test results separated by 24 hours? Yes No N/A  Are you awaiting results of a COVID-19 test? | If tested positive and or awaiting results AND did not bring proof of negative results:  STOP, Entry NOT Allowed! |
| Have you been in close contact with person(s) infected with COVID-19 who has tested positive for COVID-19 within the last 14 days? Y N | If answer is YES:  STOP, Entry NOT Allowed! |
| Obtain temperature and check for fever (>100.0).  Document temperature here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If showing or presenting symptoms of respiratory infection, including fever, cough, shortness of breath, or a combination of the listed symptoms:  STOP, Entry NOT Allowed! |
| Do you have now or in the last 14 days had the following:  Shortness of breath: Yes or No Cough: Yes or No  *OR at least two of these symptoms:*  Sore throat: Y N  Chills: Y N  Fever: Y N  Headache: Y N  Muscle Pain: Y N  Diarrhea: Y N  Repeated Shaking with chills: Y N  New loss of Taste/Smell: Y N | If answer is YES:  STOP, Entry NOT Allowed! |
| Have you taken a COVID-19 test as part of a pre-surgical requirement, Have you received your results ? Y N | If answer is YES:  STOP, Document & Verify |
| Have you traveled to OR have resided in a community with confirmed community spread of COVID-19, as identified by the CDC or state public health agency, within the last 14 days?  Y N | If answer is YES:  STOP, Entry NOT Allowed! |
| PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |