

## Coronavirus Patient Screening Tool

**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? \_\_\_\_\_

*Note: any positive response or temperature  $\geq 100.4$  °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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

Screener Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Inform patient if a mask is provided, it does not prevent spreading of the Coronavirus but is effective against the spread of the flu  
*Note: any positive response or temperature  $> 100.4$  F is considered a positive screening.*

**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: \_\_\_\_\_