COVID-19 Patient Screening Documentation

Patient Name: _____

Date of Appointment: _____ / _____ / _____

Phone Call Screening Prior to Appearance at Office

Has the patient been diagnosed or exposed to someone diagnosed with COVID-19? ☐Yes ☐No

Has the patient traveled out of the area recently? ☐ Yes ☐ No If yes, where _____

Does the patient indicate they or any member of their household have any of the following symptoms:

☐ Cough
☐ Difficulty breathing or shortness of breath
☐ Chills
☐ Fever
☐ Sore throat
☐ Muscle pain
☐ Headache
☐ New loss of taste or smell
☐ None of the above

If the patient reports any of these symptoms, advise the patient to call 911 or go to their nearest emergency room:

☐ Blue lips, face, or tongue
☐ Change in alertness or responsiveness
☐ Chest Pain or Chest Pressure
☐ Fainting
☐ Difficulty breathing
☐ None of the above

Date: _____ Initials of Staff Screener: _____

At-the-Door Patient Screening

Has the patient been diagnosed or exposed to someone diagnosed with COVID-19? ☐Yes ☐No

Has the patient traveled out of the area recently? ☐ Yes ☐ No If yes, where _____

Does the patient or any member of their household have any of the following symptoms (temperature taken by office staff):

☐ Cough
☐ Difficulty breathing or shortness of breath
☐ Temperature _____° is greater than 100.3°
☐ Chills
☐ New loss of taste or smell
☐ Sore throat
☐ Muscle pain
☐ Headache
☐ None of the above

If the patient has any of these symptoms, advise the patient to call 911 or go to their nearest emergency room:

☐ Blue lips, face, or tongue
☐ Change in alertness or responsiveness
☐ Chest Pain or Chest Pressure
☐ Fainting
☐ Difficulty breathing
☐ None of the above

Date: _____ Initials of Staff Screener: _____