First Point of Contact Screening

In order to provide a safe environment in our clinic, please answer the following questions.

(Circle one) Patient/Visitor Name: _____DOB: _____

Yes	No	Do you have any of the following symptoms?
		Fever
		Chills
		Cough
		Difficulty breathing/Shortness of breath
		Sore throat
		Body aches (other than from an injury)
		Runny nose/Nasal congestion
		New loss of taste or smell
		New rash with fever
		Nausea/Vomiting
		Diarrhea
		In the past 14 days, have you had close contact with a person confirmed to have COVID-19?
		Have you been exposed to, or suspect you may have tuberculosis (TB)?
		Have you been exposed to, or suspect you may have measles?
		Have you been exposed to, or suspect you may have chickenpox?
		Have you traveled in the past 14 days? *
If yes, where?		
		Have you been in close contact with someone who traveled in the past 14 days? *
If yes, where did they travel?		

OFFICE USE ONLY

Clinic: _____ Date: _____

(Check one) Form completed by patient/visitor ☐ Form completed by staff member ☐

Action taken (complete all that apply):	Initials	Time
Temperature: _____*If Applicable		
None, screening negative (all "no" answers)		
For any "yes" answers, give mask to an unmasked or inappropriately masked patient/visitor		
For any "yes" answers, move patient to exam room and close the door		
Patient already wearing their own mask		
For any "yes" answers, BOCS copy form and give to CM/APM		

BOCS: Consult ID Quick Guide and don appropriate PPE before entering the room. Obtain vitals inside the ID room using the blood pressure cuff barrier and no touch thermometer if available. Obtain verbal height and weight.