COVID-19 Patient Screening Guide

Patient Name:_____

DOB:_____ Patient Contact Phone #_____

Alternate Patient Contact #_____

Does patient report any of the following?

- Respiratory Symptoms(runny nose, sore throat, cough, shortness of breath) YES or NO
- Fever in last 24 hours? YES or NO
- Loss of taste or smell? YES or NO
- Nausea, Vomiting, or Diarrhea? YES or NO
- Body aches or Pains? YES or NO
- Discolored toes purplish or blue that are swollen and painful to touch? Yes or NO

Mask given to all patients and maintain social distance in waiting area if waiting in car not available.

ac 4/27/20