Patient Visitor Vendor COVID – 19 Screening

Date: _____ Screener Initials____

1. **Do you have a cough, shortness of breath, sore throat, nausea, vomiting, abdominal pain, shaking/chills, muscle aches, diarrhea, congestion, runny nose, headache, loss of taste or smell? Or have you been exposed to someone that has been diagnosed as COVID positive? Have you had a fever in the last 24 hours?**

Time	Name	Location (or phone # for non-patients)	Temp.	Passed screening? N=red dot	√ if RED DOT
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	
				Y / N	

PROCESS

1. Patient/visitor/vendor –take temp, ask questions. If negative (no symptoms, no temp) give sticker & mask.
2. For Patients – mark where they are going. For others, note phone number (for contact tracing if needed)
3. If positive – red dot sticker, give mask and place check mark (√) in column for red dot.