**Corona Virus Brief Screen – Walk in Center**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If being referred from another facility/agency, name of agency and/or individual referring:**

Name of agency/caller: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring facility/agency should place mask on accepted patient. We may patient without a mask.**

**Did referring agency administer a Covid test: yes / no if yes, what date: \_\_\_\_\_\_\_\_\_\_\_\_\_ type: rapid / standard**

**Anticipated date of results: \_\_\_\_\_\_\_\_\_\_\_\_ Symptoms present to cause testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Have you had a COVID Vaccination?  Yes  No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Last Dose: |  | Location: |  | Type: |  |

1. Have you had a COVID Test within the last 14 days?  Yes  No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: |  | Location: |  | Result: |  |

1. Have you been close to 10 or more people within a confined space during the last 2 weeks?

Yes  No

1. Have you had close contact with a known or suspected case of COVID-19 (Corona Virus) within the last 14 days?

Yes  No

1. Have you had any of the following symptoms ***now or in the last (2) weeks***: (if they answer ‘yes’ to any symptoms, but NO to questions 1 and 2 above, have them put on a mask and proceed with the screening process)

|  |  |  |  |
| --- | --- | --- | --- |
| Fever | Chills | Headache | muscle weakness |
| body aches | Fatigue | Cough | Shortness of breath |
| Congestion | sore throat | Runny nose | recent loss of sense of taste/smell |
| Nausea | vomiting | diarrhea | denies all symptoms |

If any of above systems checked, onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If an individual is answering positively on any of the above questions, Staff should don full PPE when assessing the patient and notify the provider when presenting.***

Print Staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_