**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_