UCA
UROLOGY CENTERS OF ALABAMA

COVID-19 Screening Questionnaire

1. Have you or has anyone in your house been tested for COVID-19 coronavirus in the past 14 days? ❒ No ❒ Yes

   If YES, 1) What the date of the test? _____ 2) What were the results? _____

2. Have you or has anyone in your house had contact with someone who was diagnosed with COVID-19 coronavirus in the past 14 days? ❒ No ❒ Yes

   If YES, 1) What the date of the test? _____ 2) What were the results? _____

3. Are you experiencing any of the following symptoms?

   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Fatigue
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea

   ❒ No ❒ Yes If **YES**, please describe symptoms and date of onset. _____

FOR UCA TEAM MEMBERS: If all responses are **NO**, the patient may be scheduled for an appointment.

For any **YES** response(s) that are not emergent, please delay scheduling the patient for 14 days.

For any **YES** response(s) that are emergent, please forward appropriately to the following to determine if patient can be scheduled for an appointment:

- Physician's Nurse or Triage Nurse if appointment is being scheduled via telephone or patient portal
- Physician's Nurse if patient is in-house for further evaluation and follow-up with physician

ALL Patients scheduled for an appointment should be instructed that if at any time after scheduling an appointment he/she becomes exposed to anyone who has tested positive and/or has developed symptoms of COVID-19, that he/she should call and reschedule his/her appointment.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Patient/Visitor Signature Date

_____ _____

UCA Team Member Signature Date

Updated 7/1/2020