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

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