Point-of-Care Patient Screening Form

TEMPERATURE: __________

NAME: ______________________________ **DATE:** __________

QUESTIONS	ANSWERS
Does patient have fever or have you/they felt hot or feverish recently (the last 14 days)?	☐Yes ☐No
Does the patient have shortness of breath or other difficulties breathing?	☐Yes ☐No
Does the patient currently have a cough?	☐Yes ☐No
Does the patient have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐Yes ☐No
Has the patient experienced recent loss of taste or smell?	☐Yes ☐No
Has the patient been in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐Yes ☐No
Has the patient traveled in the past 14 days?	☐Yes ☐No