Logo, company name

Description automatically generatedVisitor COVID-19 Symptom Screening

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient initials or employee host: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unit or Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccination Status: YES\_\_\_\_\_NO\_\_\_\_\_

Please read each question carefully.

|  |  |  |
| --- | --- | --- |
| **Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?** | | |
| • Fever (>100.4 F) or chills | Yes | No |
| • Cough | Yes | No |
| • Shortness of breath or difficulty breathing | Yes | No |
| • Unexplained fatigue | Yes | No |
| • New loss of taste or smell | Yes | No |
| Have you tested positive for COVID-19 in the past 10 days? | Yes | No |
| Are you currently awaiting results from a COVID-19 test? | Yes |  |
| Have you been diagnosed with COVID-19 by a licensed healthcare provider (for example, a doctor, nurse, pharmacist, or other) in the past 10 days? | Yes | No |
| Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider? | Yes | No |
| • Headache | Yes | No |
| • Muscle or body aches | Yes | No |
| • Sore throat | Yes | No |
| • Congestion or runny nose | Yes | No |
| • Nausea or vomiting | Yes | No |
| • Diarrhea | Yes | No |

Any “yes” answers to the yellow highlighted questions and visitor will be asked to leave the hospital. If answer “yes” to any of the other questions, a rapid COVID-19 Antigen test must be given.

Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please note all test results are reported to MT DPHHS.