CORONAVIRUS (COVID-19) SCREENING TOOL

Form must be completed for intra-facility transfers or transfers to other facilities (e.g. other counties, Department of State Hospitals, etc.).

CHECK ONE:	☐ Intra-Facility Transfer ☐ External Facility Transfer

PATIENT NAME:		**XREF#:**		**DOB:**	
TEMPERATURE:		**DATE:**		**TIME:**	

SENDING FACILITY:		**RECEIVING FACILITY:**	

☐ **YES** ☐ **NO**	Has the sending facility had confirmed cases of COVID-19 or any other communicable diseases (measles, mumps, influenza, etc.) in the past 14 days?	
	IF YES, DESCRIBE	

☐ **YES** ☐ **NO**	Has the patient had a fever above 100.4 degrees in the last 7 days?		
☐ **YES** ☐ **NO**	Has the patient been tested for COVID-19 in the last 14 days?	Date:	
		Results:	

CHECK ALL NEW, NON-SPECIFIC SYMPTOMS THE PATIENT HAS REPORTED/BEEN OBSERVED TO HAVE:

☐ Abdominal pain	☐ Muscle pain	☐ Sore throat	☐ Repeated shaking with chills
☐ Vomiting	☐ Loss of appetite	☐ Headache	☐ New loss of taste or smell
☐ Diarrhea	☐ Fatigue	☐ Chills	

☐ **YES** ☐ **NO**	Have you been within close contact (6 feet) of someone who has tested positive for COVID-19 in the last 14 days?

☐ **YES** ☐ **NO**	Do you have any chronic/underlying medical condition(s)? *If yes, list below.* (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease)
Comments:	

DISPOSITION (CHECK ONE):	☐ Intra-Facility Transfer	☐ External Facility Transfer

Staff Name (Print) _____ Staff Signature _____ Date _____