**COVID-19 HIGH RISK PATIENT/VISITOR SCREENING FORM**

Please complete the following form prior to proceeding with your visit.

I am a: \_\_\_\_\_ Patient \_\_\_\_\_ Visitor

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a fever, cough, shortness of breath, or difficulty breathing?

\_\_\_\_\_ Yes \_\_\_\_\_ No

1. In the last 30 days, have you traveled outside of the United States or had any contact with anyone who has?

\_\_\_\_\_ Yes \_\_\_\_\_ No

1. Have you had any contact with a confirmed or probable case of COVID-19 or person with acute respiratory illness (fever, cough, shortness of breath) who has traveled outside of the US in the last 30 days?

\_\_\_\_\_ Yes \_\_\_\_\_ No

1. Are you in the health care profession? If yes, have you been in contact with anyone who has tested positive for COVID-19?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_