PRE-VISIT COVID-19 SCREENING

Name _____ Date of Birth _____

Introduction:
I would like to speak to *[name or patient with scheduled visit]*. I'm calling from Paige Holt MD and Glori Traeder CNP Plastic Surgery & Aesthetics with regard to your appointment scheduled for *[date and time]*. The safety of our patients and staff is of utmost importance.

Given the recent COVID-19 outbreak, I'm calling to ask a few questions in connection with your scheduled appointment. These are designed to help promote your safety, as well as the safety of our staff and other patients.

We are asking the same questions to all practice patients to help ensure everyone's safety. So that we can ensure that you receive care at the appropriate time and setting, please answer these questions truthfully and accurately

All your responses will remain confidential. As appropriate, the information you provide will be reviewed by one of our practice's medical professionals who will provide additional guidance regarding whether any adjustments need to be made to your scheduled appointment.

Questions:
(Please circle Yes or No)

(Yes / No) Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit?
(If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped.)

(Yes / No) Have you or a member of your household been tested for COVID-19?
(If yes, obtain the date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms.)

(Yes / No) Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers?
(If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started and stopped and the current health status of the person who was advised.)

(Yes / No) Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers?
(If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the person quarantined, when any symptoms started and stopped and the current health status of the person who was advised.)

(Yes / No) Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?
(If yes, obtain the facility name, location, reason for visit/treatment and dates.)

(Yes / No) Have you or a member of your household traveled outside the U.S. in the past 30 days?
(*If yes, obtain the city, country and dates.)*

(Yes / No) Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days?
(If yes, obtain the city, state and dates.)

(Yes / No) Have you or a member of your household traveled on a cruise ship in the last 21 days?
(If yes, determine the name of the ship, ports of call and dates.)

(Yes / No) Are you or a member of your household healthcare providers or emergency responders?
(If yes, find out what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus a furloughed firefighter.)

(Yes / No) Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?
(If yes, obtain the status of the person cared for, when the care occurred, what the care was.)

(Yes / No) Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19?
(If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)

(Yes / No) To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?
(If yes, obtain information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred.)

I will share this information with a medical professional in our practice. Please note that our office requires that all patients and visitors follow CDC guidance regarding face coverings to prevent the spread of COVID-19. For that reason, we ask that you please wear a cloth face covering or mask to your appointment. Unless you hear otherwise from us, we look forward to seeing you at your appointment on *[date/time].*

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS FORM, AND THAT THE INFORMATION I PROVIDED ABOVE IS COMPLETE, ACCURATE AND UP-TO-DATE TO MY KNOWLEDGE.

Patient Signature _____ Date _____

Provider Signature _____ Date _____