Patient Pre-Visit Screening Tool

Patient Name: ____

Please let us know if you, your immediate household or anyone who has been in your home have any of the following (check the appropriate box):

	Yes	No
Feel ill, have a fever greater than or equal to 100.0° F (37.8° C), muscle aches, chills, headache, loss of taste or smell or other respiratory symptoms such as shortness of breath, sore throat, new or changed cough (not associated with any other condition like allergies or smoking)?		
Have you traveled internationally or on a cruise-ship within the last 14 days?		
Have you or anyone in your household had close contact * with someone who has confirmed or presumed COVID-19 (Coronavirus) within the last 14 days?		

Close contact is defined as someone who was within 6 feet or less of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the person is isolated.