AAC

COVID-19 Screening Form

Name: _____ Date: _____

Best phone number to contact you: _____

Emergency contact: _____ Phone number: _____

Birth Date: _____

_____ Yes _____ No Have you travelled outside of Alabama within the last 14 days?

Locations: _____

_____ Yes _____ No Temperature > 100.4 _____ Recorded Temperature

_____ Yes _____ No Have you had contact* with a person with a confirmed case of COVID-19?

_____ Yes _____ No Have you had contact* with a person with a suspected case of COVID-19?

***Contact is defined as less than 6 feet separation for more than 15 minutes without adequate personal protective equipment.**

_____ Yes _____ No Have you had a fever within the last 14 days?

_____ Yes _____ No Have you had a forceful dry cough or productive cough within the last 14 days?

_____ Yes _____ No Have you had difficulty breathing or shortness of breath within the last 14 days?

_____ Yes _____ No Have you had chills or repeated shaking with chill within the last 14 days?

_____ Yes _____ No Have you had new unexplained muscle pain within the last 14 days?

_____ Yes _____ No Have you had new or atypical headache for you within the last 14 days?

_____ Yes _____ No Have you had nausea, vomiting or diarrhea within the last 14 days?

_____ Yes _____ No Have you had a sore throat within the last 14 days?

_____ Yes _____ No Have you been tested for COVID-19 in the last 2 weeks?
Yes exception if done for preoperative screening, indicate below

_____ Yes _____ No Have you had a recent sudden loss of taste or smell?

Additional Notes:

_____

_____

Advice given: ____ Return home. Contact personal physician or local Health Department

____ Conservative treatment, low suspicion for COVID

Signature: _____ Date: _____