PORTER STARKE SERVICES
Health • Balance • Hope

COVID-19 (Coronavirus) Screening

This tool, the screening criteria, and recommended precautions are subject to change based on new information from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC).

Client Name: _____ Date: _____ Time: _____ AM/PM

Notes to Staff:

- *Symptoms may appear anywhere from 2-14 days after exposure, but average within 5 days.*
- *The information collected here helps our physicians make the best decisions for client care and treatment.*
- *The questions and client answers do not necessarily exclude admission to Inpatient Care Center.*

For all settings or services:

SYMPTOMS

1. **Have you experienced any of the following symptoms in the last <u>seven days</u>?**

Temperature of >99.1°F Include feeling feverish.	❑ No	❑ **Yes:** Describe: _____ Onset: _____
	If client has had a fever of ><u>100°F</u>, client cannot be admitted until: fever free, unmedicated for a minimum of 72 hours. If unknown if client has been unmedicated, they must be fever free for seven days.	
Loss of Taste or Smell	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Severe Headache	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Muscle/Joint Pain	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Weakness	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Cough	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Shortness of Breath	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Sore Throat	❑ No	❑ **Yes:** Describe: _____ Onset: _____
Other Flu-like Symptoms	❑ No	❑ **Yes:** Describe: _____ Onset: _____

If the client is presenting with any of the above symptoms (Question 1), remove the client from common areas. When contacting the physician regarding disposition for admissions, please inform the provider of all relevant assessment information.

For consideration for Inpatient Care Center admission:

RISK FACTORS

2. **What is your current age?** _____
3. **Are you currently pregnant?** ❑ No ❑ Yes
4. **Are you immunocompromised (e.g. cancer, HIV, hepatitis C)?** ❑ No ❑ Yes

Have you come in contact with anyone suspected of having COVID-19, or have you cared for someone suspected of having COVID-19, within the last 14 days? ❑ No ❑ Yes

If Yes, please state the person(s) and level of contact: _____

_____

Note: Clients will be screened by nursing staff for symptoms at the time of their arrival to the Inpatient Care Center. If clients present with fever or other concerns at that time, further consultation with the medical provider will occur prior to admission to the Inpatient Care Center.

Client Signature: _____ Date: _____

Staff signature: _____ Date: _____