INTAKE
INFECTIOUS DISEASE SCREENING FORM

PATIENT IDENTIFICATION STICKER

Have you or anyone in close proximity (lives/works with you) traveled outside of the U.S. in the last month?

□ No □ Yes – list: _____

_____

-If Yes, and the location is China or other locations associated with the COVID-19 virus (See list).

-Perform Hand hygiene and don PPE

-Provide the patient a surgical mask and escort to private location

-Notify Infection Control/Designee for further assessment.

Contact the Physician/Practitioner if the individual visited any of the known countries of outbreak.

Physician/Practitioner: _____

Date Contacted: _____ Time Contacted: _____

Comments: _____

_____

Do you have any of the following signs and symptoms?

___ Persistent cough for 2 weeks
___ Coughing up blood
___ Chest pains
___ Shortness of breath
___ Night sweats
___ Rapid weight loss
___ Severe loss of appetite
___ Running fever
___ Lived with anyone that had confirmed TB
___ Had a positive TB skin test in the past

Date of Last TB Test: _____ □ Unknown

If you have tested positive, list medications taken: _____
When was your last chest x-ray? _____ Results: _____

If **3 or more** of the above are present provide a surgical mask for the person being screened and contact the admitting practitioner to determine if additional screening at a medical facility is indicated. Document the practitioner decision through either order to send to medical facility or to proceed with assessment.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____