



For questions about screening criteria, please  
forward an HICS 213 to Operations Chief at System IC.

Registration:  
SCAN FORM TO  
PATIENT CHART

CURRENT COVID-19 Guidance - last updated August 6, 2020

## Patient Screening Guidelines

Print Patient's LEGAL Name:

Last

First

Middle

Sex: \_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Appointment Type \_\_\_\_\_

### Observable or Self-Reported Symptoms and Exposures:

- ☐ Fever greater than 100°F, or has medicated to treat a fever over 100°F in the last 4 hours
- Patient Temperature: \_\_\_\_\_
- ☐ Cough or shortness of breath, new or worsening within last 7 days
- ☐ Patient is awaiting confirmation of a COVID-19 laboratory result.
- ☐ Patient has tested COVID positive, and does not have a letter of release from health department OR has new symptoms.
- ☐ In the past 14 days, patient has been closer than 6 feet for more than 15 minutes to a person confirmed to have COVID-19, and at least one person was not masked.
- ☐ At least **TWO** of the following symptoms, if **NEW** within the past 7 days (mark symptoms reported):
- |                                   |                                |  |  |                               |  |
|-----------------------------------|--------------------------------|--|--|-------------------------------|--|
| <input type="radio"/> sore throat | <input type="radio"/> headache | <input type="radio"/> runny nose       | <input type="radio"/> loss of taste or smell | <input type="radio"/> fatigue | <input type="radio"/> muscle aches or pain         |
| <input type="radio"/> nausea      | <input type="radio"/> vomiting | <input type="radio"/> nasal congestion | <input type="radio"/> diarrhea               | <input type="radio"/> chills  | <input type="radio"/> repeated shaking with chills |

**ANY ONE box checked above indicates  
the patient's visit should be rescheduled.**

Screener Completing Form:

Name \_\_\_\_\_ Date/Time \_\_\_\_\_

Print Name