

Facility name: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Screener name: \_\_\_\_\_ Visitor name: \_\_\_\_\_ Visitor phone #: \_\_\_\_\_

Resident name: \_\_\_\_\_

### COVID-19 Screening Assessment

	(circle)	<u>Concerns/Comments</u>
Does the screener observe any signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath?	Yes No	_____ _____ _____ _____ _____ _____ _____ _____
Does the visitor indicate any potential signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath?	Yes No	_____ _____ _____ _____ _____ _____ _____ _____
In the last 14 days, has the visitor had contact with someone with a confirmed diagnosis of COVID-19 or under investigation for COVID-19?	Yes No	_____ _____ _____ _____ _____ _____ _____ _____
Has the visitor traveled to any locations with current COVID-19 transmissions within the last 14 days?	Yes No	_____ _____ _____ _____ _____ _____ _____ _____