WINDSONG
WHERE PATIENTS COME FIRST

COVID-19 SCREENING FORM

Please circle your answers

***Please bring completed form to your appointment**

1. Have you been in contact with anyone who currently has COVID-19 or is currently under Quarantine for COVID-19 within the last 2 weeks? ____________________________________ YES NO

2. Have you had the following COVID symptoms within the last 2 weeks?

   "Newly Developed" Cough/ Shortness of Breath or difficulty breathing? ________________ YES NO

   Chills/ Shaking with Chills? ____ YES NO

   "Flu like symptoms" (Headache, Muscle Pain, Sore Throat)? __________________________ YES NO

3. Have you had a fever within the last 3 days?_______________________________________ YES NO

4. Are you under evaluation for COVID-19 and waiting for the results of a viral test to confirm infection?____ YES NO

5. Have you been diagnosed with COVID-19 and not yet been cleared to discontinue isolation?____ YES NO

Patient Name: ______________________________ Patient Signature: ______________________________

Date ___________________

Jacket Number (for staff to fill out) _________________________________

OFFICE USE ONLY

Temperature assessment to be completed at the facility upon arrival by Windsong Staff.

□Pass □Fail (If fail, staff to advise the patient that a Supervisor/Manager will speak with them.)