**Colony Square Eyecare Patient Covid-19 Screening Questionnaire Form**

***As of May 11, 2020; subject to revision***

IMPORTANT: This screening questionnaire is not a substitute for your obligation to monitor your own health. We ask that you take your own temperature at home before leaving to come to the facility, and that you stay home if you have a temperature or any other symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, extreme fatigue/body aches). In addition, if anyone in your household or anyone you have been in recent direct contact with has any symptoms of COVID-19, do not come to the facility. By writing and signing your name below, you acknowledge that you are consenting to be seen at your own risk and you also consent to following the safety protocols instituted by Colony Square Eyecare.

**Guest Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_**

**Temp: Less than or equal to 99.5°F Temp: Greater than 99.5°F (Do not admit to clinic) Please answer the following questions:**

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| --- | --- |
| A.1. Have you been tested for, or suspected of having, COVID-19? | YES **€** NO |
| A.2. If tested and positive, have you been certified as recovered/noninfectious by a physician? Please provide a copy of this certification. | YES **€** NO |
| A.3. If tested and negative, have you been symptom free for at least 14 days? | YES **€** NO |
| *If the answer to A.1. is “Yes”, and either A.2. or A.3. are “No”, do not continue with or schedule your next appointment until 14 days have passed or you are certified as testing negative for active infection.* |  |
|  |  |
| B.1. Has anyone in your household been tested for, or suspected of having, COVID-19? | YES **€** NO |
| B.2. Has that person been symptom free for at least 14 days? | YES **€** NO |
| *If the answer to B is “Yes”, and the answer to B.2. is “No”, do not continue with or schedule your next appointment until the household member identified in question B has been symptom free for 14 days, or until you can produce a result demonstrating that you are non-infected.* |  |
|  |  |
| C.1. Have you been in direct contact with someone outside of your home who has been diagnosed with or tested for COVID-19? | YES **€** NO |
| C.2. If so, have you been symptom free for 7 days? | YES **€** NO |
| *If the answer to C.1. is “Yes” and the answer to C.2. is “No”, do not continue with or schedule your next appointment until you have been symptom-free for a total of 7 days from the date of contact with the individual identified in C.1.* |  |
|  |  |
| D.1. Have you or anyone in your household had a persistent cough and/or other respiratory symptoms in the past 24 hours? | YES **€** NO |
| D.2. Have you or anyone else in your household had at least two of the following symptoms in the past 24 hours? -- Fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.  | YES **€** NO |
| *If the answer to D.1. or D.2. is “Yes”, do not continue with or schedule your next appointment until you or the household member are without symptoms or fever for at least 72 hours* |  |

**Screener Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_