 Patient Screening for Covid-19

 Quality Behavioral Health 75 Lambert Lind Hwy, Warwick RI, 02886

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To prevent the spread of Covid-19 in our community and reduce the risk of exposure tour staff and other patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

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| --- | --- |
| Name | Date |
| Provider | Time of visit |

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| --- | --- |
|  | Self-declaration by patient |
| 1 | Please circle any of the following symptom(s) you have had in the last 2 weeks.  Fever Sore throut Dry cough Body aches  Runny nose Tiredness Headache Shortness of breath Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2  | Have you been in contact in the last 14 days with a person that has tested positive for Covid-19? No Yes |
| 3 | Have you travel out of the state of Rhode Island in the past 14 days No Yes |

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| For office use only |  |
| Staff checking in | Was face mask worn by paitient Yes No |