**COVID-19 (CORONA VIRUS) SURVEILLANCE FORM**

# ED / CLINIC PATIENTS

Updated 3/18/20

Name:_____Date:_____

- **For all patients, this screening form must be completed upon every visit.**
- Patients are defined as those presenting to ED and appts for treatments or tests.

## SECTION A: IDENTIFY

1. In the last 30 days have you traveled outside the country or taken a cruise?
   - ❑ Yes Dates:_____
   - ❑ No

   **IF YES, WHERE**:_____**(determine if this is a current high risk area)**

2. Have you been to a domestic area with community incidents?
   - ❑ Yes Date:_____
   - ❑ No

3. Have you had close contact with someone who has been known to have COVID 19
   - ❑ Yes Date:_____
   - ❑ No

4. Have you had a Fever (100.4 degrees F.), Cough, Shortness of Breath in the last 24hours?
   - ❑ Yes Date:_____
   - ❑ No

## SECTION B: ACT

- **If YES to any of the above**, ask them to put on a mask, wash hands, and escort patient to designated room (ie. ultrasound room).
- **ED Family - Allowed 1 Guardian and Must be screened!**
  - **Yes to any of above**??
    - Apply mask, wash hands, and ask them to **refrain from waiting inside the hospital.**
- **Vendor or sales person**, have them wait outside and contact the area they are wishing to visit. Departments have protocols in place.
- **In person requests for medical records or billing questions**- Keep patient at the door and have them call from home; 406.822.4841. If patient requests to pay a bill; Take payment if requested and mail receipt.