COVID-19 Screening

Vehicle Info	Color:
Make:	Model:

Name/Nombre: ___________________________Date of Birth/Fecha de Nacimiento:______________ Sex/Sexo: M______ F______

Address/Direccion:____

City/Ciudad:_____________________________________ State/Estado: ___________ Zip Code/Codigo Postal:__________________

County of Residence/Condado de Residencia: ________________ Employer or School/Empleador o Escuela: ___________________

Home Phone#/Telefono de Casa:___________________________ Cell Phone/Telefono Cellular:______________________________

Insurance/Seguro:______________________________________ Policy or Subscriber ID/Numero De Poliza:____________________

Race/Raza:____ Ethnicity/Etnicidad: ______________________________________

Subjective/Sintomas	Yes/Si	No/No	Comment / Onset if symptomatic Comentarios/ Inicio de sintomas
Subjective Fever (felt feverish) / Fiebre Subjetiva (Se sintio con fiebre)			
Cough / Tos			
Chills / Escalofrios			
Muscles Aches / Dolores Musculares			
Runny Nose / Escurrimiento Nasal			
Sore Throat / Dolor de Garganta			
Change in taste or smell / Cambios en Sabor o Olfato			
Headache / Dolor de Cabeza			
Fatigue / Fatiga			
Wheezing / Resollar (ronquido en el pecho)			
Short of Breath / Falta de Aire			
Difficulty Breathing / Respiracion Deficultosa			
Chest Pain / Dolor en el Pecho			
Nausea or vomiting or Diarrhea / Nausea, Vomito, or Diarrea			
Abdominal Pain / Dolor Abdominal			
Other, specify: / Otro, Especifique:			
Traveled outside the US in the last 6 months? / ¿Ha viajado fuera de los Estados Unidos en los últimos 6 meses?			
Contact with anyone that has test positive for COVID-19? / ¿Ha estado en contacto con alguien que haya resultado positivo para COVID-19?			

*************************************** **Medical Office Staff Use Only** **

Location:_________________________________ Date of Service:___________________________ Results of Test:________________

Objective (please answer vitals and constitution for all asymptomatic patients)

Must have at least three (3) Vitals: Temp _______ Pulse Ox _______ HR _______ RR _______ Ht._______ Wt._______ BP_______

Observational Assessment of Constitution: Well-developed _________ Well-nourished __________ No apparent distress_________

If symptomatic, please complete as applicable

Cardiac: Normal S1 S2_____________________ No murmurs or gallops____________________

Pulmonary: Clear to auscultation bilateral (+ / -) Rhonchi (+ / -) Wheezes (+ / -) Rubs (+ / -)

Other: ____

Assessment/Plan

1. Perform COVID-19 test
2. Review answers to the list of symptoms, Review the vitals and elements of Physical Exam performed.
3. Follow-up Plan/Instructions
    a. Goshen will contact the patient with the results of the test.
    b. Goshen will contact the patient’s local health department for all “positive” test results so that the Local Health department can contact the patient for quarantine and potential contact tracing

Provider Signature ____