Comanche County Medical Center

COVID-19 SCREENING TOOL

Patient Name:	DOB:	Patient Phone #:
Address:	Date:	Time: Pt's PCP:

Welcome to the CCMC COVID-19 Screening answering service. Your care is important to us. We would like to ask a few questions to help provide the best patient care for you. Please answer the following:

1. Have you traveled within the last 30 days?
   a. Yes or No
   b. If yes,
      i. Where/Destination:_____
      ii. Dates of Travel:_____
      iii. Airport/Airline:_____
2. To your knowledge have you been in contact with someone who recently traveled?
   a. Yes or No
   b. If yes,
      i. Where/Destination:_____
      ii. Dates of Travel:_____
      iii. Airport/Airline:_____

3. To your knowledge have you been exposed to COVID-19?
   a. Yes or No
4. To your knowledge have you been expose to someone diagnosed with COVID-19?
   a. Yes or No

Comments: _____

Please tell us the following symptoms you are experiencing?

o Fever – Current Temp_____ o Cough o Shortness of Breath o Any other Respiratory Symptoms?_____	o Headache o Chills o Nausea/Vomiting/Diarrhea o Muscle Aches o Abdominal Pain	Have you recently been tested for FLU? Yes or NO

Thank you for answering these questions. With the information you have provided our recommendation at this time is: (Please see back of page for algorithm on treatment)

As always, if you feel your situation is emergent and you need emergency services you should report to the ER. We ask that you call ahead so they can get a room ready and assist you from waiting in the waiting room.

Signature of Screener:_____