**COVID-19 CHECKLIST SCREENING TEMPLATE FOR PATIENTS**

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**Questions:**

Have you or a member of your household had any of the following symptoms in the last 14 days: sore throat, cough, chills, congestion, body aches for unknown reasons, shortness of breath or difficulty breathing for unknown reasons, fatigue, loss of smell, loss of taste, fever, nausea/vomiting/diarrhea? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped).

  YES  NO Details:

Have you or a member of your household been tested for COVID-19? (If yes, obtain the date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms).

  YES  NO Details:

Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started and stopped and the current health status of the person who was advised).

  YES  NO Details:

Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the person quarantined, when any symptoms started and stopped and the current health status of the person who was advised).

  YES  NO Details:

Have you or a member of your household visited or received treatment in a hospital, nursing home, long term care, or other health care facility in the past 30 days? (If yes, obtain the facility name, location, reason for visit/treatment and dates).

  YES  NO Details:

Have you or a member of your household traveled outside the U.S. in the past 14 days? (If yes, obtain the city, state and dates).

  YES  NO Details:

Have you or a member of your household traveled in the U.S. in the past 14 days? (If yes, obtain the city, state and dates).

  YES  NO Details:

Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, obtain the status of the person cared for, when the care occurred, what the care was).

  YES  NO Details:

Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain the information about the believed source of the potential exposure and any signs that the person acquired the virus).

  YES  NO Details:

To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19? (If yes, obtain information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred).

  YES  NO Details:

 ***Signed:***

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