COVID-19 Assessment Information

Patient Name:			**D.O.B:**
Address:			**Phone:**
Today's Date:			
Assessment Criteria	**Yes**	**No**	**Comments**
A) Did/Does the patient have a fever? (Fever may not be present in some patients, use clinical judgment to guide testing)			**Fever onset date: ___/___/_____** **Highest measured temperature: _____** ☐ ◦**F** ☐ ◦**C** ☐ Check if SUBJECTIVE fever only
B) Does the patient have symptoms of lower respiratory illness (LRI)? (e.g. cough or shortness of breath)? *Check all that apply			**Symptoms onset date: ___/___/_____** ☐ Cough ☐ Sore throat ☐ Difficulty breathing ☐ Chills ☐ Repeated shaking with chills ☐ Muscle pain ☐ Headache ☐ New loss of taste or smell ☐ Shortness of breath or difficulty breathing **Other Symptoms (list):**
C) In the 14 days before symptom onset, did the patient: **i. Have close contact with a lab-confirmed COVID-19 patient?**			**Dates of contact with COVID-19 lab-confirmed case: ___/___/____ to ___/___/_____** **Name of contact lab-confirmed case (if known):** **_____** **Name of contact:** ☐ Family/Household ☐ Coworker ☐ Healthcare worker ☐ Travel ☐ Other: _____ **Comments: _____**
ii. Travel from affected geographic areas? CDC Coronavirus Travel Information: http://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html			**Dates: ____/____/_____ to ____/____/_____** **Arrival in U.S.: ____/____/_____** **Locations visited in 14 days before symptoms onset:**
Suspect COVID-19 if you answered YES to • **A or B and Ci** • **A and B and Cii**			

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