Infection Prevention and Control Manual
Interim Screening Tool for Suspected or Confirmed Coronavirus (COVID-19)

Coronavirus-(COVID-19)

Resident Symptom Evaluation

Room Number	Resident Name	*Fever or Chills	Cough	Shortness of Breath or Difficulty Breathing	Fatigue	Muscle or Body Aches	Headache	New Loss of Taste or Smell	Sore Throat	Congestion or Runny Nose	Nausea or Vomiting	Diarrhea	Signature of Screener

***Fever is defined as a temp of T≥100.0◦F or more than 2 temperatures >99.0 F**

Unit	
Shift	
Date	
Signature	

This resource was developed utilizing Information from CDC and CMS.
Providers are reminded to review state and local specific information for any variance to national guidance

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Staff Symptom Evaluation

Employee Name	Exposure to someone with COVID-19 in last 14 Days?	Fever (100.0 or higher) or Chills	Cough	Shortness of Breath or Difficulty Breathing	Fatigue	Muscle or Body Aches	Headache	New loss of taste or smell	Sore Throat	Congestion or Runny Nose	Nausea or Vomiting	Diarrhea	Signature of Screener

Shift	
Date	
Signature	

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Visitor Symptom Evaluation

Visitor Name	Exposure to someone with COVID-19 in last 14 Days?	Fever (100.0 or higher) or Chills	Cough	SOB or Difficulty Breathing	Fatigue	Muscle or Body Aches	Head-ache	New Loss of Taste or Smell	Sore Throat	Congestion or Runny Nose	Nausea or Vomiting	Diarrhea	Signature of Screener

Shift	
Date	
Signature	

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