COVID-19 Consumer Health Screening

Consumer: _____

Mode of contact: ☐ **Phone** ☐ **In-person** ☐ **Senior Center**

Contact with: ☐ **Consumer**
☐ **Family/Caregiver**
☐ **Home Care Worker**
☐ **Other:** _____

AREAS OF CONCERN (Check all that apply)

☐ Limited or no formal or informal supports
☐ Caregiver stress/deficits in ability to care for self and consumer/caregiver unavailable
☐ Home care issues/problems with home care provider/unmet ADL/IADL needs
☐ Mental health concerns and/or emotional distress
☐ Social isolation/loneliness
☐ Food insecurity/nutritional risks
☐ Other: _____

COVID-19 SCREENING	Initial		Pre-Visit	
	Date:		Date:	
	Yes	No	Yes	No
1. Are you, or any one you are living with, experiencing any of the following symptoms? • Fever (100+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell If yes, when, what, and steps taken to receive medical attention:	☐	☐	☐	☐
2. Have you, someone with whom you have had contact, or any one you are living been diagnosed with a positive test and/or by a health care practitioner for COVID-19?	☐	☐	☐	☐
3. Have you, someone with whom you have had contact, or any one you are living with been ill for reasons other than COVID-19?	☐	☐	☐	☐
4. Have you or someone with whom you have had contact been asked to self-quarantine?	☐	☐	☐	☐

Staff Signature: _____ Title: _____ Date: _____