**Infection Control Screening**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of Survey Completion: (Please circle one) **In Person Phone Call**

Reason for Call/Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient/client been told by a medical person they should be quarantined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the below signs or symptoms? (Please check all that apply)

**\_\_ Fever Temp: \_\_\_\_\_\_\_F \_\_ Cough**

**\_\_ Difficulty Breathing/Shortness of Breath**  \_\_ Chest Congestion

\_\_ Nasal/Sinus Congestion \_\_ Runny Nose

\_\_ Poor Appetite \_\_ Dizziness

\_\_ Body Aches \_\_ Chills

\_\_ Headache \_\_ Nausea/Vomiting

\_\_ Stomach Cramps/Abdominal Pain \_\_ Describe Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Date Symptoms Began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Did you work or attend any public areas since symptoms began? (if so, describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who have you been in contact with since symptoms began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you contacted or seen a doctor? **Yes No**
* If you received a diagnosis, what was it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you been hospitalized for this illness? **Yes No**
* Have you traveled outside the country within the past 14 days? **Yes No**
* If so, what country did you travel to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What date did you arrive home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had close contact with anyone with a laboratory confirmed COVID-19 or Patient Under Investigation (PIU) for COVID-19? **Yes No** Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Please complete the information on the reverse of this form**.

**Interviewer Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read the information below to the caller:**

Please call your doctor if you have any symptoms of illness, but especially if you have fever, cough, shortness of breath, abdominal cramps, or sore throat, or if you have recently traveled from China, Iran, Italy, Japan, South Korea or other areas with widespread/ongoing community spread of COVID-19. The most current list of countries with travel restrictions can be found at cdc.gov.

If any signs or symptoms of illness are recorded on this form, you need to call DPH to be screened and follow their recommendations. Please call **1-866-408-1899.**

Interviewer, please initial here after reading the above to the staff member: \_\_\_\_\_\_\_\_\_\_\_\_

**If the patient or visitor reports having any of the above symptoms and is:**

**on the phone**: let the person know you are going to read them something then you are going

to ask them to hold to speak with a supervisor**.**

**outside the clinic**: ask the person to remain outside and let them know you are going to get a

supervisor.

**Inside the clinic:** immediately place on a mask and gloves and ask the patient to so the same.

Remain at least 6 feet away from the patient at all times. Let the patient know you are going to

get a supervisor. The supervisor or designee will then initiate the potential exposure protocol.

**If any of these happens, please circle which protocol you followed**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*\*Recording interviewer, please scan and email this form to [Mary.Wise@delaware.gov](mailto:Mary.Wise@delaware.gov) and [April.Johnson@delaware.gov](mailto:April.Johnson@delaware.gov)