**COVID-19 Patient Screening**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Bounce Back Physical Therapy is to monitor the health status of everyone (patients/visitors/staff) that will be entering the clinic. Prior to scheduling the initial evaluation, conduct a screening to identify patients at risk for having COVID-19 infection. Asks the patients about the following:

1. International travel or to states with a high prevalence of COVID within the last 14 days with sustained community transmission? Yes ( ) No ( )

2. Signs or symptoms of typical and atypical signs of COVID infection, such as:

Fever Yes ( ) No ( )

 Cough Yes ( ) No ( ) Sore throat Yes ( ) No ( )

Shortness of Breath Yes ( ) No ( )

 Diarrhea Yes ( ) No ( )

 Loss of smell or taste Yes ( ) No ( )

3. In the last 14 days, has had contact with someone with or under investigation for COVID19, or are ill with respiratory illness? Yes ( ) No ( )

4. Residing in a community where community-based spread of COVID-19 is occurring?

 Yes ( ) No ( )

5. Anyone in their home that is or have been ill? Yes ( ) No ( )

If you suspect the patient exhibits possible symptoms based on the screening tool, please inform the patient to contact their physician. The therapist will also contact the patient’s physician to indicate therapy will not be started until patient is cleared. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 or Indiana Department of Health website.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Patient cleared for initial evaluation appointment
* Reviewed by therapist prior to the initial evaluation
* Follow- up needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_