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PATIENT TRIAGE CHECKLIST

NAME:_____ DOB:_____

DATE:_____ PHONE:_____

- Do you have a fever? ☐ Yes ☐ No
- Do you have a cough or respiratory symptoms? ☐ Yes ☐ No
- Have you been in contact with someone who has A confirmed diagnosis of COVID-19 within the last 14 days? ☐ Yes ☐ No
- Have you traveled out of the country within the last 14 days? ☐ Yes ☐ No
- COVID-19 Vaccinated? ☐ Yes ☐ No

  If yes, when: _____
  (Date)

If you have answered "Yes" to any of the questions listed above, we will notify your provider about your clinical situation for the next steps.

Thank you,
G&K Medical