COVID-19 Screening
INTAKE FORM

(TO BE PROVIDED TO PATIENT PRIOR TO ASSESSMENT)

Patient: Please complete the form below.

This Intake Form is intended to be used as a screening tool prior to the assessment for temporary emergency housing placement services. This is not a diagnostic tool for determining COVID-19. All patients with confirmed or suspected cases of COVID-19 should follow CDC and physician guidance and refrain from physical contact with all others until directed by a medical professional.

To be completed by patient or patient's legal guardian if under 18 years of age:

First Name: _____ Last Name: _____
Date of Birth: _____/_____/_____ Month Day Year

Please Indicate **YES or NO** in the appropriate field below. Are you currently experiencing any of the following symptoms:

Fever greater than 100.4 °F (38.0 °C) within the past 72 hours YES □ NO □

Shortness of breath YES □ NO □

Cough YES □ NO □

Chills YES □ NO □

Chills with repeated shaking YES □ NO □

Muscle Pain YES □ NO □

Headache YES □ NO □

Sore Throat YES □ NO □

Loss of taste or smell YES □ NO □

Nausea/Vomiting or Diarrhea YES □ NO □

Are you ill or caring for someone who is ill? YES □ NO □

Have you been in contact with a person who has tested positive for COVID-19

YES □ NO □ within the past 2 weeks?

Have you or someone in your place of residence contracted COVID-19? If yes, when? YES □ NO □

I attest that the information provided above is to my knowledge is accurate and true Patient Signature_____ Date_____