

PATIENT AND VISITOR SCREENING FORM

OSHA requires our healthcare facility to screen ALL individuals prior to entry.

Form must be completed on the DAY of your visit/appointment.

One form per individual required. Visitors must also complete before entry is allowed.

If completed at home, please bring your form to our office.

YOUR NAME: _____ **TODAY'S DATE** _____

1. Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?

- Fever greater than or equal to 100.4 degrees
- New, unexplained cough associated with shortness of breath
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell without any other explanation
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

NOTE: If you checked ANY of the above boxes, please phone our office at 912/790-4000 and reschedule your appointment. If you are a visitor, please do not enter our facility.

2. Have you been diagnosed with COVID-19 by a licensed healthcare provider in the past 10 days?

- Yes
- No

NOTE: If you checked YES on any of the above boxes, please phone our office at 912/790-4000 and reschedule your appointment. If you are a visitor, please do not enter our facility.

3. Have you tested positive for COVID-19 in the past 10 days?

- Yes
- No

NOTE: If you checked YES on any of the above boxes, please phone our office at 912/790-4000 and reschedule your appointment. If you are a visitor, please do not enter our facility.

4. Are you currently awaiting results from a COVID-19 test?

- Yes
- No

NOTE: If you checked YES on any of the above boxes, please phone our office at 912/790-4000 and reschedule your appointment. If you are a visitor, please do not enter our facility.

5. Have you been told you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days?

- Yes
- No

NOTE: If you checked YES on any of the above boxes, please phone our office at 912/790-4000 and reschedule your appointment. If you are a visitor, please do not enter our facility.