Coronavirus COVID-19: Patient Risk Survey

Name:_____

DOB:_____

Date:_____

Verbal Screening:

1. Have you traveled out of state in the past 30 days? Yes No
2. To your knowledge, have you been in contact with a COVID-19 patient? Yes No
3. Are you experiencing any of the following flu-like symptoms?
    a. Cough Yes No
    b. Shortness of breath Yes No

Or, at least two of these symptoms:

c. Fever Yes No
d. Chills Yes No
e. Repeated shaking with chills Yes No
f. Muscle pain Yes No
g. Headache Yes No
h. Sore throat Yes No
i. New loss of taste or smell Yes No

Visual Screening:

Please complete visual assessment based on patient's physical appearance:

- Coughing Yes No
- Sneezing/runny nose Yes No
- Pale skin Yes No
- Fatigued Yes No
- Sweating Yes No

Patient Notice to Reschedule:

Verbiage: Hi, it does not appear that you are feeling well today. Dr. _____ is recommending that you seek further medical evaluation, considering the Coronavirus, for your health and safety. I am going to help reschedule your visit at least two weeks from today. For your safety, if you are still not feeling well, please give us a call and we can push your visit back until you feel better. How does _____ at _____work for you?

Confirmation Calls: Every Patient, One Day Prior to Visit

Verbiage for confirmations: Hello, this is _____ from (insert practice name). I am calling to remind you of your dental appointment on _____ at _____. We want you to know that we follow the highest standard of infection control procedures and are committed to your health and safety. If you have traveled outside of the U.S. within the past 30 days or are experiencing flu like symptoms, we are happy to reschedule your visit for a time when you are feeling better. We are happy to return a call to confirm at _____. Thank you and have a nice day.