Patient Name:_____
Date of Procedure:_____
Doctor:_____
Nurse Signature:_____
Date:_____

USPI

CORONAVIRUS (2019-nCoV) SCREENING FORM

At Texas Endoscopy there is no higher priority than your well-being and the broader health of our communities. We understand the fear and concern surrounding this outbreak, and we are committed to doing all we can to keep you and your family healthy and offer you peace of mind. Our top priority, as always, is to deliver safe, high-quality care to you and all patients that we serve."

In order to provide the utmost safety for our patients and team members, we request that you limit the number of people who will accompany you on the day of your procedure to only 1 adult who may be asked to remain in their car. Please do not bring children with you. We also request that you please answer the following questions:

- Have you or the person(s) who will accompany you on the day of your procedure been in close contact with anyone who is a laboratory confirmed or suspected case Coronavirus in the past 14 days? Yes No
  - If yes: Did anyone develop a fever or respiratory symptoms (cough, shortness of breath) Yes No

- Have you or the person(s) who will accompany you on the day of your surgery traveled outside the country in the past 14 days? Yes No
  - If yes, where? _____
- Have you or the person who will accompany you traveled outside the state in the past 14 days?
  - If yes, where? _____
  - If yes: Did anyone develop a fever or respiratory symptoms (cough, shortness of breath)? Yes No

- Have you or the person(s) who will accompany you on the day of your procedure had a severe acute lower respiratory illness with no source of exposure or alternative explanatory diagnosis (i.e. influenza, pneumonia) Yes No

- **Signs and Symptoms:** Have you had any of the following symptoms:

  - Fever of 100.4 or greater Yes No
  - Cough Yes No
  - Shortness of breath or difficulty breathing Yes No
  - Sore throat Yes No
  - Headache Yes No
  - Muscle aches Yes No
  - Loss of taste or smell or appetite Yes No
  - Fatigue Yes No
  - Diarrhea Yes No
  - Nausea or vomiting Yes No
  - Congestion or Runny Nose Yes No
  - Chills, includes repeated shaking with chills Yes No