# ARK-LA-TEX CHILDREN'S CLINIC COVID-19 PREVISIT SCREEN:

**DATE: _____ PHYSICIAN/NURSE PRACTITIONER SEEING PATIENT: _____**

**PATIENT NAME:_____ DOB:_____**

**ACCOMPANIED BY:_____**

**CELL PHONE #:_____ RELATIONSHIP TO PATIENT:_____**

**TODAY'S VISIT IS A:** ☐ ***WELL*** ☐ ***SICK*** ☐ ***ADHD*** ☐ ***PROBLEM* VISIT** ☐ **SHOT ONLY** ☐ **Ear Piercing**

**HAS YOUR INSURANCE CHANGED?..... ☐ YES ☐ NO ☐ NO INSURANCE**
**DO YOU HAVE A COPAY WITH YOUR INSURANCE?..... ☐ YES ☐ NO ☐ N/A**
**IF YOU HAVE A COPAY, HOW DO YOU PLAN TO PAY TODAY?... ☐ CASH ☐ CREDIT**

## DUE TO COVID-19 INFECTION CONCERNS, WE REQUIRE THE FOLLOWING QUESTIONS BE ASKED IN ORDER FOR US TO SEE YOUR CHILD TODAY:

1. PLEASE CHECK OFF ANY SYMPTOM THAT YOU, YOUR CHILD, OR ANY CLOSE CONTACTS HAVE HAD DURING THE LAST WEEK:

| | | |
|---|---|---|
| ☐ FEVER &/OR CHILLS | ☐ NAUSEA &/OR VOMITING | ☐ DIARRHEA |
| ☐ MUSCLE OR BODY ACHES | ☐ HEADACHE | ☐ SORE THROAT |
| ☐ NEW LOSS OF TASTE | ☐ NEW LOSS OF SMELL | ☐ COUGH |
| ☐ SHORTNESS OF BREATH | ☐ DIFFICULTY BREATHING | ☐ CONGESTION &/OR RUNNY NOSE |

2. Have you, your child, any family members, or close contacts had any recent travel in the last 4 weeks?..... ☐ **YES** ☐ **NO**
3. Have you, your child, any family members, or close contacts tested POSITIVE for COVID-19?..... ☐ **YES** ☐ **NO**
4. Are you, your child, any family members, or close contacts waiting for results to determine if you or the person swabbed has COVID-19?..... ☐ **YES** ☐ **NO**
5. Have you, your child, any family members, or close contacts been told they may have COVID-19 and to self isolate, but were not swabbed for COVID-19?..... ☐ **YES** ☐ **NO**

**PLEASE BE ADVISED THAT WE WILL CALL YOU TO LET YOU KNOW WHEN WE WILL BE MEETING YOU AT THE DOOR TO BRING YOU BACK FOR YOUR APPOINTMENT. WE MAY ALSO CALL TO ASK FURTHER QUESTIONS ABOUT THE ANSWERS ON YOUR SCREEN. PLEASE BE PATIENT WITH US AS WE DO OUR BEST TO KEEP YOU AND YOUR CHILDREN SAFE AS WELL AS TO PREVENT THE SPREAD OF COVID-19.**

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**FOR OFFICE USE:**

**APPT TIME:_____ ARRIVAL TIME:_____**