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.

FOR OFFICE USE:

APPT TIME:_____ ARRIVAL TIME:_____