PROTECT AGAINST
COVID-19

Heritage

SKILLED NURSING

Visitor Screening Questionnaire

No	Yes	
☐	☐	I have traveled to an area that is currently restricted by state order within the last 14 days.
☐	☐	I have been in close contact with people who have traveled to countries where COVID-19 is spreading within the past 14 days.
☐	☐	I have been around people who are sick with colds or flu.
☐	☐	In the past seven days, I have had a fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea
☐	☐	I have a fever, or have had a fever within the past week (100°F or above).
_____		Current temperature

If you marked yes to any question, please postpone your visit for at least 14 days after the start of your symptoms. Contact your healthcare provider if your symptoms get worse. Thank you for understanding.

☐ I have verified a negative COVID-19 test in the last seven days.

_____ Date of negative test

_____ Name of person verifying test result

_____ First and Last Name

_____ Signature

_____ Email Address (if available)

_____ Daytime and Evening Phone Number

_____ Physical Street Address

_____ Date/Time of Visit

_____ Purpose of Visit

_____ Name of Resident Visiting

_____ Vendor (if applicable)

☐ I refuse to complete this form, and understand I will not be able to enter the facility.

Notes _____

FOR **OFFICE USE ONLY**

The person above has been cleared for visitation. Initials _____ Date/Time _____