SITRIN HEALTH CARE CENTER - COVID-19 PREVENTION SCREENING
Visitor Questionnaire

Visitor Name:_____ Date:_____ Time of Visit:_____

Resident you are visiting:_____ Unit/House:_____

Please utilize the 60% alcohol-based hand rub provided for you prior to starting your screening.

1. **Do you have verification of a COVID-19 negative test result dated within the last seven (7) days?**
   Yes – I have a COVID-19 negative test result dated within last seven (7) days
   No – I have not been tested or do not have verification of a COVID-19 negative test result.

2. **Do you have any of the following Respiratory Symptoms?**
   Please circle yes or no to each:

a. Fever	Yes / No
b. Sore Throat	Yes / No
c. Cough	Yes / No
d. Shortness of Breath	Yes / No
e. New Loss of Taste or Smell	Yes / No
f. New Body or Muscle Aches	Yes / No
g. Vomiting or Diarrhea	Yes / No

   Temperature:_____
   100.0° or higher, visitation denied

If YES to any of the above, for the safety of our residents and staff members, please refrain from visitation at this time.
If NO to all, proceed to question #2.

2. **Have you:**
   Circle any that are applicable:
   a. Traveled internationally within the last 14 days where COVID-19 cases have been confirmed?
   b. Have you worked in a health care setting with direct contact to COVID-19 patients within the last 14 days?
   c. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
   d. In the last 14 days, have you had contact with or cared for someone with a confirmed diagnosis of COVID-19 or under the investigation for COVID-19, or is ill with a respiratory illness?

If any of the above are circled, please refrain from visitation at this time.
If none are circled, proceed to question #3.

3. **Have you traveled to or from any State with the U.S., the District of Columbia, or U.S. territories within the last 14 days?**
   Please circle:
   Yes - I have traveled outside of NY State. Area:_____ Date of Return:_____
   If yes, did you test for COVID 3 days prior to coming back and then again 3 days after entry in to NY state? Yes / No
   No - I have not traveled outside of NY State within the last 14 days.

If YES, please refrain from visitation at this time.
If NO, proceed. **(PLEASE COMPLETE OTHER SIDE)**

4. Do you need a facemask? Yes / No

The section below MUST be completed for contact tracing requirements mandated by the Department of Health. Please print clearly:

Name:_____

Physical Address:_____

Daytime Phone:_____ Evening Phone:_____

Email address:_____

By signing below, I am verifying that I have received a copy of the Visitor Expectation/Fact Sheet and that I have reviewed and agree to follow the COVID-19 visitation requirements as outlined. I understand that if I violate any of the rules while visiting, that I may be prohibited from visiting for the duration of the COVID-19 state declared public health emergency. I further agree to immediately notify the Health Care Center should I develop any COVID-19 symptoms after visiting the facility for a period 14 days.

Visitor Signature:_____ Date:_____

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO THE EMPLOYEE SCREENER

This section to be completed by facility staff:

Visitor showed COVID-19 negative test result dated within last 7 days of visit? Yes / No
Paper copy received? Yes / No **OR** Reviewed test results on cellphone? Yes / No / N/A
Questionnaire completed in entirety? Yes / No Visitation approved? Yes / No
Visitation Expectation Fact Sheet given? Yes / No Visitation sticker given? Yes / No
Facemask given? Yes / No Visitor is wearing facemask properly? Yes / No
Visitor utilized alcohol-based hand rub and demonstrated proper use? Yes / No

Screener Signature:_____Title:_____Date_____

Completed Questionnaire must go in to manila envelope and returned to VP of Long Term Care Services