**SITRIN HEALTH CARE CENTER - COVID-19 PREVENTION SCREENING**

**FOR VISITATION**

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 any of the following Respiratory Symptoms?**

Please circle yes or no to each: **Temperature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Fever Yes / No 100.0° or higher, visitation denied
2. Sore Throat Yes / No
3. Cough Yes / No
4. Shortness of Breath Yes / No
5. New Loss of Taste or Smell Yes / No
6. New Body or Muscle Aches Yes / No
7. Vomiting or Diarrhea Yes / No

**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:

1. Have you worked in a health care setting with direct contact to COVID-19 patients within the last 14 days?
2. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
3. 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?
4. Have you been informed by the Health Department that you meet the criteria for a mandated quarantine due to a COVID-19 exposure?
5. **Do you need a surgical facemask (cloth masks are not permitted)?** Yes / No

1. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(PLEASE COMPLETE OTHER SIDE)**

**Sitrin Health Care Center – COVID-19 Prevention Screening for Visitation**

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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 infection control rules while visiting that I will 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.

In addition, my signature below is my attestation that I have utilized the iHealth COVID-19 test accurately, that the test results are my results and not those of someone other than me, and that the test was completed within 24 hours of my visit.

Visitor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO THE EMPLOYEE SCREENER**

*This section to be completed by facility staff:*

Questionnaire completed in entirety and reviewed? Yes / No

Visitation Guidance Sheet given? Yes / No Visitation sticker given? Yes / No

Facemask given? Yes / No Green or Yellow (please circle)

Visitor is wearing surgical facemask properly? Yes / No

Visitor utilized alcohol-based hand rub and demonstrated proper use? Yes / No

iHealth Rapid Test Results: Negative Positive Verified by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

iHealth Rapid Test given for next visit: Yes / No

Screener Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

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