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:_____
   100.0° or higher, visitation denied

   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

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. Have you worked in a health care setting with direct contact to COVID-19 patients within the last 14 days?
   b. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
   c. 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?

3. **Do you need a surgical facemask?** Yes / No

4. 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)

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.

Visitor Signature:_____ Date:_____

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE TO THE EMPLOYEE SCREENER

This section to be completed by facility staff:

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 Green or Yellow (please circle)
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