Patient Label/Vendor's name	Richmond University Medical Center	Date:______ Time:________

INFECTIOUS DISEASES SCREENING TOOL

The purpose of this questionnaire is to screen for potentially contagious infectious diseases and to protect patients as well as staff.

ALL PATIENTS/VISITORS/VENDORS AND SUPPORT PERSONS **MUST** WEAR A MASK AT ALL TIMES WHILE IN THE MEDICAL CENTER/CLINIC/OFFSITE AND OUTPATIENT AREAS

This form is to be completed at the point care for all patients/visitors/vendors/support persons:

1. Have you traveled outside the U.S. in the past 21 days (3 weeks)?
   If yes, where ________________________________ ☐ YES ☐ NO
   Has a close contact (household member) traveled outside the U.S. in the past 21 days (3 weeks) ☐ YES ☐ NO
   If yes, where ________________________________
2. Have you had close contact with a person with:
   Middle Eastern Respiratory Virus (MERS) ☐ YES ☐ NO
   Ebola/Lassa/Marburg ☐ YES ☐ NO
   Measles or Mumps ☐ YES ☐ NO
   Do you have a rash? ☐YES ☐ NO
   Chickenpox ☐ YES ☐ NO
   OR any other infectious disease? ☐ YES ☐ NO
3. Have you had close contact with a person or have you been diagnosed with:
   Novel Corona Virus (COVID-19) ☐ YES ☐ NO
   If yes, has it been more than 14 days since contact with COVID + Patient ☐ YES ☐ NO
4. Do you have a cough, shortness of breath, or a sore throat? ☐ YES ☐ NO
5. Are you vomiting or having diarrhea? ☐ YES ☐ NO
6. What is the patient's/ visitor's/Vendor's/ Support person's temperature: __________

☐ **Patients:** Permitted to enter the facility. Symptomatic and/or patients who screen positive for any infectious disease above should be placed directly into a room with door closed.

☐ **Support Persons:** Question2, if the answer is **"YES"** to both COVID questions and **"NO"** to all other infectious diseases then they are permitted in the facility.
If temp >100.0 or symptomatic, they will be asked to leave the hospital.
Question2, if support person has had contact with COVID patient in less than 14days and they are ASYMPTOMATIC; they are permitted in the facility.
Support person's name:_____________________________________

☐ **Visitors/ Vendors:** Question2, if the answer is **"YES"** to both COVID questions and **"NO"** to all other infectious diseases then they are permitted in the facility.
If temp >100.0 or symptomatic, they will be asked to leave the hospital.
Question2, if the visitor/vendor has had contact with COVID patient in less than 14 days; they will be asked to leave the hospital.

☐ I have received infection control education on proper hand hygiene and Personal Protective Equipment

Patient's Name ______________________________________Unit_______________

Signature of Visitor ____________________________________ Date______________

This document supersedes all previous ID screening tools

IC March 10, 2020, May 6, 2020, May 22, 2020, May 26, 2020, June 1, 2020, June 24, 2020

Richmond University Medical Center

<u>SUPPORT PERSON</u>

TEMPERATURE LOG

Temperature must be taken every 12 hours

Time	*Temperature*