

**Resident Intake/Admission Screening**

**YOUTH’S NAME:**

**DOB:**

**Instructions:** Please use the following information to guide medical staff and providers in determining if a patient meets criteria for COVID-19 testing.

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| --- |
|  **Travel History (international travel in the 14 days prior to symptom onset):** |
|  **Country/Province/City** | **Dates:** |
|  |  |
|  |  |
|  **Exposure history** |
| In the last 14 days, has the patient had close contact with a known or suspected COVID-19 case? | o Yes o No o Unknown |
| In the last 14 days, has the patient had close contact with someone else who had a recent travel history to a country with known transmission and became ill? | o Yes o No o Unknown |
|  **Clinical history** |
| Does the patient have a fever? | o Yes o No o UnknownIf yes, Onset date / / o Subjectiveo Measured (Tmax)  |
| Does the patient have any of the following signs or symptoms? | * Cough o Shortness of breath o Fatigue o Chills
* Diarrhea o Abdominal pain o Runny nose o Congestion
* Sore throat o Other

Earliest onset date / / |
| Did the patient have a chest x-ray? | * Not performed o Pending o Normal
* Abnormal o Pneumonia o Other

Date performed / / |
| Did the patient have a rapid influenza test? | o Not performed o Pending o Negative o Positiveo Unknown Date performed / / |
| Did the patient have a respiratory panel test? | * Not performed o Pending o Negative
* Positive for

Date performed / / |
| Do you anticipate that this patient will require admission to the hospital? | o Yes o No o Unknown |

3/19/20