GUILFORD RADIOLOGY

COVID-19 Patient Screening

Patient name: _____ Date: _____ Completed/reviewed by: _____

In the past 2 weeks:

- ✓ Have you been in contact with someone who was confirmed or suspected to have Covid?
- ✓ Have you been advised to stay home due to an illness that might be Covid?
- ✓ Have you been tested for Covid?
- ✓ Have you traveled out of CT/NJ/NY?

Do you have any of the following symptoms:

- ✓ Fever greater than 100F
- ✓ New loss of taste or smell
- ✓ New sore throat, cough, or SOB
- ✓ New chills or muscle pain
- ✓ New vomiting or diarrhea

IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS, PLEASE CONTACT US TO REVIEW

If you answered no to all questions,

- ➢ **Please call us from the parking lot when you arrive for your exam, we will instruct you when to come in. Alert us if you prefer to wait inside and we will accommodate you.**
- ➢ **All patients must always wear a mask**
- ➢ **We will take your temperature and sanitize your hands when you arrive**
- ➢ **Visitors are asked to wait in their vehicle during your exam**