

COVID-19 Screening Tool

Subject #: _____

Subject Initials: _____

Date: _____

Time: _____

Appointment Date/Time: _____

Essential Research Visits-Research visits that cannot be performed remotely and are essential to a participant's health and/or well-being may be performed in person, utilizing the guidelines in the tool below:

PARTICIPANT SCREEN

One Day prior to scheduled visit: _____

Has participant traveled in the last 30 days?

Yes Location: _____ No

If yes, does the PI approve for the screening to continue? Yes No

PI Signature: _____ Date: _____/_____/_____

Has participant had known or potential contact with suspected or confirmed case of COVID-19?

Yes No

Has participant been tested for COVID-19? Yes No

If yes, what was the result? Positive Negative

COVID-19 Test Date: _____

If *positive*, and asymptomatic – Participant must quarantine for at least 14 days following the positive screen prior to visit with no potential COVID-19 symptoms appearing in that time.

If *positive*, and symptomatic (see symptom list below) – Participant must:

- Demonstrate at least 8 days free of symptoms, defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) prior to visit
- Have a negative COVID-19 test result prior to visit

Date of COVID-19 Retest: _____

Participant temperature within the last 24 hours: _____

Has participant experienced any of the following signs/symptoms* in the past 3 days?

**COVID-19 testing should be considered if patient reports 1 or more signs/symptoms with no alternate explanation/diagnosis*

Fever

Cough (dry or productive)

COVID-19 Screening Tool

Subject #: _____

Subject Initials: _____

Date: _____

Time: _____

Appointment Date/Time: _____

Shortness of breath

Viral prodrome (headache, nausea, vomiting, diarrhea)

Time screening completed: _____

Staff Signature: _____ Date: ____/____/____

Morning of scheduled visit: _____

Has participant traveled in the last 30 days?

Yes Location: _____ No

If yes, does the PI approve for the screening to continue? Yes No

PI Signature: _____ Date: ____/____/____

Has participant had known or potential contact with suspected or confirmed case of COVID-19?

Yes No

Has participant been tested for COVID-19? Yes No

If yes, what was the result? Positive Negative

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Fever

Shortness of breath

Cough (dry or productive)

Viral prodrome (headache, nausea, vomiting, diarrhea)

Time screening completed: _____

Staff Signature: _____ Date: ____/____/____

ACCOMPANYING CAREGIVER SCREEN

One Day prior to scheduled visit: _____

Has accompanying caregiver traveled in the last 30 days?

Yes Location: _____ No

If yes, does the PI approve for the screening to continue? Yes No

PI Signature: _____ Date: ____/____/____

Has accompanying caregiver had known or potential contact with suspected or confirmed case of COVID-19? Yes No

Has accompanying caregiver been tested for COVID-19? Yes No

If yes, what was the result? Positive Negative

COVID-19 Test Date: _____

If *positive*, and asymptomatic – Accompanying caregiver must quarantine for at least 14 days following the positive screen prior to visit with no potential COVID-19 symptoms appearing in that time.

If *positive*, and symptomatic (see symptom list below) – Accompanying caregiver must:

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Time: _____

Appointment Date/Time:

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- Have a negative COVID-19 test result prior to visit
Date of COVID-19 Retest: _____

Accompanying caregiver temperature within the last 24 hours: _____

Has accompanying caregiver experienced any of the following signs/symptoms* in the past 3 days?

**COVID-19 testing should be considered if accompanying caregiver reports 1 or more signs/symptoms with no alternate explanation/diagnosis*

Fever

Shortness of breath

Cough (dry or productive)

Viral prodrome (headache, nausea, vomiting, diarrhea)

Time screening completed: _____

Staff Signature: _____ Date: ____/____/____

Morning of scheduled visit: _____

Has accompanying caregiver traveled in the last 30 days?

Yes Location: _____ No

If yes, does the PI approve for the screening to continue? Yes No

Staff Signature: _____ Date: ____/____/____

Has accompanying caregiver had known or potential contact with suspected or confirmed case of COVID-19? Yes No

Has accompanying caregiver been tested for COVID-19? Yes No

If yes, what was the result? Positive Negative

COVID-19 Test Date: _____

If *positive*, and asymptomatic – Accompanying caregiver must quarantine for at least 14 days following the positive screen prior to visit with no potential COVID-19 symptoms appearing in that time.

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Fever

Shortness of breath

Cough (dry or productive)

Viral prodrome (headache, nausea, vomiting, diarrhea)

Time screening completed: _____

Staff Signature: _____ Date: ____/____/____

REMINDERS FOR CAREGIVER:

1. Please bring a thermometer with you on the morning of visit to do another screen just before our visit. Please call when you have arrived so we can screen before leaving your vehicle.
2. We ask that only 1 person accompany the patient to the visit.
3. The study staff will put on masks and gloves while in contact with patient and caregiver. We will ask that you and patient don a mask also.
4. We will ask that you and patient wash your hands before entering the clinic. A staff member will provide you with hand sanitizer at the door. Then we will put on gloves.
5. We have taken extreme measures to clean all equipment and will be cleaning as we use equipment throughout the visit.