COVID-19 Screening Referral Form

Date of Call: ___________________ Time of Call: __________________

Agency Individual was Referred From: _______________________________

Name of Employee Making Referral: _________________________________

Client Name: __________________________________ Age: ___________________

Does this individual have a fever? ____Yes _____No

*If yes, what is the temperature? __________

Does this individual have a cough? ____Yes _____No

Is this individual experiencing shortness of breath? ____Yes ____No

Is the individual over 65-years-old? ____Yes _____No

Does this individual have diabetes, heart disease, high blood pressure, lung disease, or any immunosuppressant illness? _____Yes ____No

*If yes, please specify. ____

Referral to Medical Provider

Medical Provider Contacted for Telehealth Screening: _________________________________

Results of Telehealth Screening:

Need Testing? Yes ___ No ____

Need Isolation: Yes ____ No ____

Time Deemed Appropriate for Isolation: _____________________

Referral to Ambulatory Service & Isolation Location

Time of Call: ___________________ Name of Employee: _____________________________

Time of Pick Up: ________________