Indianapolis CoC COVID-19 Screening Tool

Before you start… Stop and call 911 if client presents with any of these symptoms:

- Constant chest pain or pressure
- Extreme difficulty breathing
- Severe, constant dizziness or lightheadedness
- Slurred speech
- Difficulty waking up
- Blueish lips or face

First, become familiar with symptoms of COVID-19 and how they differ from the flu and allergies:
COVID-19: fever, cough, shortness of breath
Flu: Fever, cough, sore throat, headaches, body, muscle aches, runny, stuffy nose, fatigue
Allergies: Sneezing, coughing, runny nose, scratchy throat, itchy, red watery eyes

Client Name*: _____ **Age:** _____

SSN: _____ - _____ - _____ **Gender:** _____

Home Phone: _____ - _____ - _____ **Email:** _____

SCREENING INFORMATION:

Screening Date*: _____ / _____ / _____ | **Current Temp:** _____ °F

Symptoms (choose all that apply): ☐ Fever ☐ Cough ☐ Shortness of breath ☐ Tiredness ☐ Aches and pains ☐ Nasal congestion ☐ Loss of smell ☐ Runny nose ☐ Sore throat ☐ Diarrhea

Existing Conditions (choose all that apply): ☐ Chronic lung disease ☐ Asthma ☐ Serious heart condition ☐ Immunocompromised (including cancer treatment) ☐ Severe obesity (BMI > 40%) ☐ Diabetes ☐ Renal failure ☐ Liver disease ☐ Currently pregnant ☐ HIV or AIDS ☐ Transplant recipient

☐ **Known exposure to COVID-19** ☐ **Previously tested**

CURRENT TEST:

Status: ☐ Taken ☐ Sent ☐ Pending ☐ Returned | **If "Returned:"** ☐ Positive ☐ Negative ☐ Unknown

RESULT OF SCREENING:

☐ Asymptomatic Low Risk ☐ Asymptomatic High Risk ☐ COVID-19 Exposed ☐ COVID-19 Positive

TELEHEALTH: CONTACT HEALTH CARE INFORMATION:

Contact health care provider: ☐ Yes ☐ No **| Contact local hotline:** ☐ Yes ☐ No