COVID-19 Community or Facility COVID-19 Screening Tool for Protective Services

Older Adult: _____ **SAMS ID#:** _____

Mode of contact: ☐ **Telephone** ☐ **In-person**

Contact with: ☐ **Older Adult**
☐ **Family/Family Caregiver** _____
☐ **Other/Caregiver** _____
☐ **Other:** _____

COVID-19 SCREENING	**Initial** Date:		**Pre-Visit** Date:	
	Yes	No	Yes	No
1. Are you, or anyone you are living with, experiencing any of the following symptoms? • Fever (100.4+), cough, shortness of breath or difficulty breathing, diarrhea, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell If yes, when, what, and steps taken to receive medical attention or consultation:	☐	☐	☐	☐
2. Are you, someone with whom you have had contact within the last 14 days, or anyone you are living with been ill or been diagnosed with COVID-19? *For the caseworker*: If the older adult or someone they are living with had been ill or was previously diagnosed with COVID-19; however, show no current symptoms or illness, discuss with your supervisor regarding scheduling a visit.	☐	☐	☐	☐
3. Have you or someone with whom you have had contact been asked to self-quarantine within the last 14 days?	☐	☐	☐	☐
4. Have you, someone with whom you have had contact in the last 14 days, or anyone you are living with traveled out of the state or country in the last 14 days?	☐	☐	☐	☐

Staff Signature: _____ Title: _____ Date: _____